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of Chronic Obstructive
Pulmonary Disease
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M.D.*

Drowning: A Seasonal
Nightmare
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Development of Human
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Published monthly (since 1904), under direction of the Committee on Publication, by The Medical Society of New Jersey, 315 West State St., Trenton, N.J. Printed in Hanover, New Hampshire by the Dartmouth Printing Co. Whole number of issues 863. Member's subscription (\$5) is included in Society dues. Rates for nonmembers, \$10; outside USA add \$2.50 for postage. Single copies, \$1. Address communications to *The Journal*, MSNJ, P.O. Box 904, Trenton, N.J. 08605 (609) 394-3154. Second class postage paid at Trenton, N.J. and additional entry office. Copyright 1976 by The Medical Society of New Jersey.



July 1976

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EDITORIALS

A Medical Career for Our Children

At our request, several former New Jersey residents, who have reached the heights of success in their medical careers, were asked to comment on the effects of extra-medical pressures on physicians and the career-planning of their children. Some colleagues argue vigorously that they have dissuaded their offspring from a career in medicine because of government interference and controls, consumerism, the superabundance of red, white, and blue tape, and the professional liability-malpractice problem. Staying on the pedestal nowadays is a bit like logrolling for the physician because of unreasonable public expectations.

Others feel differently — and that is what makes horse races! Before you direct your son or daughter toward a non-medical career, ask yourself what better choice there is with so many challenges, satisfactions, and opportunities. Also, read the special article by Alton I. Sutnick, a former Trentonian, who is Dean of the Medical College of Pennsylvania (see page 62! this issue).

A.K.

Cause and Effect

From time to time, the manuscript review board and editor of this *Journal* reject an article on the basis of its unscientific conclusions. This is more likely to occur when sweeping but unproved deductions are made from a single case observation or from a small number of interesting medical events. One must hasten to state that individual experiences and anecdotal data may occasionally prove to be valid and may lead to major discoveries. Yet, having recognized that possibility, we still must not publish speculative material in the guise of "hard data" which cannot be supported. To do so can produce harm to patients and to the author's credibility. How

many times have you read retractions of material honestly published as scientific fact at some earlier time? Unfortunately, not often enough.

The fact that A and B exist in the same patient does not mean that A caused B! Examples of this are numerous. The finding of reactive hypoglycemia in a psychoneurotic, middle-aged female does not tell us that functional hyperinsulinism causes psychoneurosis. The finding of an unusual anomaly in a patient who happened to be taking a certain drug for an unrelated condition does not automatically say that *that* drug caused *that* defect. It is possible that it did, but one needs more than the conjectural evidence of their coexistence in the same patient.

The scientific method is an orderly research procedure. A problem is identified and relevant data are gathered by various techniques of examination. One may formulate a hypothesis, based on these data, and then test it by empirical, provable, verifiable experiments and observations. Each element of the scientific method — problem, data-collection, hypothesis, and replicability — is essential.

When preparing medical manuscripts — whether case reports, anecdotal series, or therapeutic trials — one must consider the scientific method before he is privileged to conclude a situation represents cause and effect. To do otherwise is simply "guesstimation" — a postulational exercise which must be identified as such and not as scientific deduction. A. K.

Nosocomial-Iatrogenic Nutritional Deficits

A casual review of hospital experience will show many patients miss breakfast because of a gastrointestinal x-ray series, preceded by a venipuncture to draw blood for a hemogram, SMA 12/60®, electrolytes, and lipid profile. Patients who have a three- to six-hour glucose tolerance test usually miss breakfast and sometimes lunch without having the nutrients repaid. Elderly and confused patients have food

trays come and go without tasting a morsel — for various reasons. Victims of diarrhea and/or vomiting are given symptomatic treatment plus one or two liters of saline or electrolyte solutions, with or without five percent dextrose. Surgical patients are treated for days with electrolyte-dextrose solutions without supplementation, after gastric or intestinal resection.

Butterworth* recently accused physicians of “frank mismanagement, if not downright neglect, of the patients’ nutritional health in our hospitals.” There appears to be justification of such criticism in light of standard operational procedure in many hospitals as described above. It hardly can be argued that the quality of the problem is unimportant, since wound healing, susceptibility to infection, development of anemia, hypoproteinemia, and liver function relate directly to nutritional balance. Muscle, nerve, and bone integrity clearly depend on exogenous nutrients.

Among the specific deficiencies to be found in hospitalized patients the range is broad and not difficult to document. They include protein-calorie malnutrition to the point of adult marasmus, multiple vitamin deficiencies including scurvy, hypocalcemia, anemia, hypomagnesemia, and iron deficiency. A small study at the University of Alabama disclosed a weight loss averaging 6 kg. in 61 percent of patients; there was an average of 3.1 days with no food by mouth. Hypoalbuminemia was present in 28 percent of patients at admission, and in another 9 percent before discharge. Anemia was seen in 37 percent at admission while an additional 16 percent developed anemia in the hospital. Caloric deficiencies were estimated to be 2,600 for each patient for each week of hospitalization.

*Butterworth CE, Jr.: The skeleton in the hospital closet. *Nutrition Today* 9:4-8, March/April 1974.

The “healthy” victims of this variety of deprivation may suffer little permanent disability, but there are some who will have more devastating effects. Most susceptible to nosocomial nutritional deficits are the elderly with poor dentures, poor appetites, and confusion, alcoholic patients with chronic liver disease, psychotic individuals with little interest in food, victims of malabsorption from any of many causes, cancer patients, and those with extensive burns or renal disease.

Preventive action, which is obviously needed in this instance, is at hand if we follow certain guidelines. Height and weight should be recorded on every hospital patient. Nurses and nutritionists must observe patients’ food habits and intake and should alert physicians to problems. The nutrients of meals withheld because of diagnostic tests should be made up in some way. Preoperative patients who are depleted of essentials should have a period of repletion before undergoing major surgery. We must recognize and provide for the added nutritional requirements of hyperthyroidism, infection, wound healing, bone healing, subsiding hepatitis, and diabetics who have lost much weight, especially juvenile diabetics. Remember that frequent venisections for laboratory studies over extended time periods remove a good deal of iron which may need replacement. Tube feedings may be inadequate if not carefully prescribed, while blind administration of vitamin mixtures may be a snare and a delusion. Regular evaluation of nutritional status by selected laboratory procedures is a must. Glucose and saline intravenously is not very nourishing!

Prompt attention to these matters is bound to pay dividends directly to our patients. We may not be able to provide Julia Childsean fare to our hospital patients, but it should at least be balanced and healthful.

A.K.

PATRONIZE OUR ADVERTISERS

Commentary

Standards for Medical School Minority Students

In recent weeks, the College of Medicine and Dentistry of New Jersey and its New Jersey Medical School in Newark became the subject of accounts in the news media which focused on academic problems of two minority-group students. Because the community injected itself into the matter — a not unusual situation these days — and because of the rather oversimplified nature of media reporting, the pursuit of proper disposition of the students' status became the central issue obscuring the very complex institutional problems that beset not only our College, its students and its faculty, but the nation at large. Indeed, the issues with which we must cope are but a microcosm of the national controversy.

Whenever an institution of higher education, whose graduating students can expect great individual economic opportunity, is utilized also as a vehicle for social change, conflict is bound to ensue. To require an institution such as a medical school to operate as an agent of change within this atmosphere of tension and to fulfill its usual role in the traditional manner may indeed be unrealistic and unreasonable. Academic standards, quality, and performance are necessary and intrinsic to medical education; adding racial and social overtones to an already complex situation makes them more undefinable than ever.

Admissions committees, residency review commissions, and licensing boards long have grappled with the need to establish criteria that might delineate clearly the characteristics of the best and most successful physician. We all are aware of examples where undergraduate performance, examination grades, class standings, national boards, AOA recognition, and other standards have seemed inadequate to the task, not only of selecting the individual for professional education but of insuring his or her being accepted by both patients and peers as a competent practitioner. Each of us performs with differing levels of expertise, depending upon our abilities, personalities, and capabilities.

The controversy concerning minority-student acceptance and performance is not unique to our medical schools or to New Jersey, as witness the recent apparently contradictory decisions concerning medical school admissions by the courts in California, which condemned so-called reverse discrimination, and by those in New York, which uphold that very concept as a temporary means of fulfilling the requirements of the Fourteenth Amendment to the Constitution.

Obviously, the courts continue to have difficulties in coming to sensible, logical, and fair conclusions concerning issues of such social import as equal opportunity in admissions criteria, student performance, and "double-standards." We continue to look to the courts for resolution, but in the meantime we are forced to do the best we can, given society's — and our own — value judgments, criteria, and sensitivities to social issues.

Most of us were perhaps less than fully prepared for such circumstances, and we find ourselves involved in a form of "on the job training." Lacking proven alternatives, we continue to apply traditional methods and measures of performance to new groups of students from different social and cultural backgrounds. We also continue to search for the alternatives without diluting the effectiveness of the academic process or lowering the status and quality of the profession.

It may well be that the struggle over busing, which is yet to be settled, and the controversies of the last ten to fifteen years within our schools and colleges have now reached our professional educational institutions, and we are coping no better than did our colleagues.

The topic of minority student performance received much formal and informal discussion during the April, 1976, meeting of the Council of Deans, representing most United States medical schools. A recent article in the *New England Journal of Medicine* (294:1118, 1976) highlighted

the anguish with which faculties have endured the controversy involving standards, performance, and social objectives. The article has since been rebutted by the President and the Dean of Medicine at Harvard and by Dr. John Cooper, President of the Association of American Medical Colleges, (*The New York Times*, May 19, 1976).

There is no doubt that one of the most significant elements in this conflict has been the lack of a sizable pool of suitable minority applicants. This problem continues to beset all health professions' schools, including ours in New Jersey, despite conscious and conscientious efforts to solve it by our colleagues in the State's undergraduate facilities and by nationally acclaimed programs sponsored by CMDNJ. The CMDNJ Students for Medicine and Students for Dentistry summer educational programs only recently were applauded by independent evaluators as "probably the best in the United States," a recognition of which all New Jersey can be proud. Despite indications by both quality of applicant and student performance that the pool is improving, much remains to be accomplished.

The recent confrontation at the CMDNJ-New Jersey Medical School centered around the academic and clinical performance of two minority students. Both had arrived within three months of graduation by routes that were less than smooth. One was in the fifth year of study because of prior academic problems; the other took courses in reverse order because of personal circumstances.

In both cases, prior academic problems served as warning that either had gone unheeded or had been removed by appropriate adherence to school requirements that, very honestly, were in the process of evolution as the faculty learned to cope with new problems. The element of lateness of course completion in fulfillment of requirements (end of fourth year) was complicated by perceptions and denials of racial discrimination, which can at times also serve as an issue to obscure as well as one requiring rectification.

Nevertheless, despite prior warnings and recognized evaluative and subjective difficulties,

both students faced the need to repeat a course, based upon performance on an oral examination given without the benefit of the presence of a minority faculty member. Although one can argue whether or not the latter is a valid point, it had been repeatedly recommended as part of the format for oral examinations. The central issue, therefore, became one of fairness rather than of individual student performance. It would be unfair to address further the specifics of the performance of these two students. They have received re-examination under what most believe to have been acceptable conditions for evaluation by the appropriate school procedures and faculty committees.

For the future, serious consideration is being given to the matter of oral examinations and to possible requirements for anonymity on written examinations to avoid even any implication of the effects of external factors. In addition, efforts will be made to achieve a broader-based involvement by many constituencies in determination of those parameters which might best indicate the successful performance of medical and dental school graduates.

A continuing short-term problem remains. It is that of recruiting adequate numbers of qualified black and other minority-group faculty, including women, as representation among previously excluded groups grows on our campuses. This faculty is essential to serve as role models and points of contact and reference for students. Of course, the continuation of this trend, nationally stimulated by Federal affirmative action programs and grant awards, plus endorsement by the Association of American Medical Colleges, will depend on accessibility to professional education opportunities in the face of restrictive tuition levels and burdensome loan programs that in themselves have the potential for discrimination. There is a danger that the health professions may once again turn toward elitism, or at least toward those capable of payment without unreasonable obstacles. Service by all graduates may be another worthwhile social goal; hopefully, it will not become another element in the current controversy.

When the issue of the apparent academic failures of the two minority students became

known to the Dean and the President, attempts were made to arrive at a fair and reasonable solution with the full knowledge that extreme opposite positions had already been taken by the major portion of our minority students and community representatives on one side, and by representatives of the departments and some faculty on the other side. Despite a series of meetings with all parties and the extensive involvement of the Board of Concerned Citizens, an advisory group to the CMDNJ Board of Trustees, no generally acceptable middle ground was reached by Friday, April 2, although the Faculty Council had taken what seemed to many to be a reasonable position.

The result was a direct confrontation with black students and the community, who joined to pose significant questions in opposition to the CMDNJ-New Jersey Medical School Faculty Council. The former presented a series of twelve demands. Eight affected all students at our school and, with minor modifications, were accepted as the basis for possible improvements, some in the educational program, some in student-faculty relations and some in minority-student representation in committee activities.

Two other items were referred to appropriate committees and academic procedures for faculty review. On one the department involved subsequently responded favorably; the other was rejected by the faculty committee and subsequently by the Faculty Council.

The demand that the two students in question have an opportunity for re-evaluation under the Dean's direction following a brief tutorial program was accepted as a reasonable resolution to an original decision of the Faculty Council that this period be a four-week clerkship. The demand for the dismissal of a faculty member was rejected by the Dean and the President.

Not all the faculty agreed with the re-evaluation decision, and some from within and without our institution have indicated that the school was "intimidated" or "blackmailed." Yet the solution allowed retesting in what the students felt would be an improved environment, devoid of some of the previously noted accusations of prejudice. The students were well aware that failures

could mean repeating the entire course, or possibly the full year of study. Since graduation and the initiation of internships and residencies were in jeopardy, if the courses were to be repeated without retesting, many felt that the alternative represented a fair solution to a complicated and unusual set of circumstances.

We believe that the school, instead of exhibiting "weakness" or succumbing to "intimidation," has evidenced consideration and understanding for two students who, for whatever their personal reasons, found themselves at the center of a serious social issue that our country has not yet been able to answer — as witness recent events in Boston. Despite the relative youth of our institution (whose location was directed by our State leaders) and the inherent difficulties of using an educational institution to try to accomplish a social goal, we believe that we have shown the strength to face repeated issues of this type and survive and improve from the experience.

While we would be the last to indicate internal unity on all such issues, we note a growing strength of conviction that we will be able to adapt and develop programs and procedures to respond to the situation without destroying standards of performance or accountability. We will still produce graduates who will be able to meet the licensing requirements of our State and serve its people without risk or question of competence.

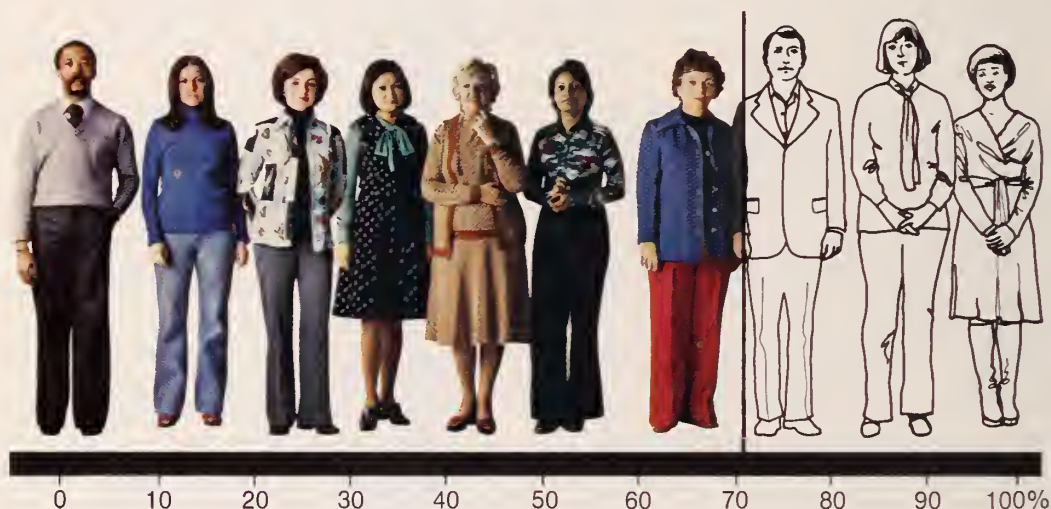
Long before the current minority performance issue came before faculties and administrators, students encountered academic difficulties, failed initial attempts at licensure and were allowed special programs in order to justify society's investment and trust.

We will continue to review our criteria for admission, performance of students and requirements for graduation, as well as to work with the mandates of the majority of our society. We trust that we will carry out our responsibilities in an efficient and competent manner, with a concern for all our students and their needs, ever mindful that it is the patient we ultimately must serve and protect.

Stanley S. Bergen, Jr., M.D.

In a multicenter study of patients with chronic or frequently recurrent urinary tract infections

BactrimTM was 27.2%* more in keeping patients



Bactrim—70.5% of 78 patients infection-free at 8 weeks



ampicillin—55.4% of 74 patients infection-free at 8 weeks

*This percentage is arrived at by the statistical method of dividing the difference between Bactrim and ampicillin results (15.1%) by the percent of ampicillin results (55.4%).

†Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey 07110.

effective than ampicillin infection-free for 8 weeks.[†]

10-day Bactrim[™] therapy outperforms 10-day ampicillin therapy.

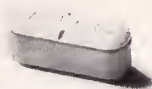
In a multicenter, double-blind study of patients with chronic or frequently recurrent urinary tract infection, 10-day therapy with Bactrim outperformed ampicillin 10-day therapy by 27.2% when comparing patients who maintained clear cultures for 8 weeks. When compared at the end of therapy, 90.4% of 83 Bactrim-treated patients had clear cultures in contrast to 81.7% of 82 ampicillin-treated patients. Of even greater significance is the fact that a higher percentage of Bactrim-treated patients maintained clear cultures for 8 weeks. Criterion for "clear culture" was 1000 or fewer organisms/ml urine.

Adverse reactions noted in this study were relatively mild, e.g., nausea, vomiting, rash. However, more serious side effects can occur with the agents studied. Please see product information of each manufacturer for complete listing of adverse reactions.

Note: Bactrim tablets were used in these clinical trials. Bioequivalency studies show one Bactrim DS double strength tablet is equal to two Bactrim tablets.

Bactrim[™] DS

(160 mg trimethoprim and 800 mg sulfamethoxazole)



Double Strength tablets/Just 1 tablet B.I.D.

Bactrim[™]

(80 mg trimethoprim and 400 mg sulfamethoxazole)



2 tablets B.I.D.

For chronic or frequently recurrent cystitis and pyelonephritis due to susceptible organisms.

Please consult summary of product information on following page.

ROCHE

Significant Prescribing Factors:

- Primarily for chronic or frequently recurrent cystitis and pyelonephritis due to susceptible strains of *E. coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris* and *Proteus morganii*.
- Usual therapy 10 to 14 days.
- Contraindicated during pregnancy or the nursing period.
- Maintain adequate fluid intake; perform frequent CBC's and urinalyses with microscopic examination.
- SxT sensitivity discs available to test sensitivity to Bactrim.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Chronic urinary tract infections evidenced by persistent bacteriuria (symptomatic or asymptomatic), frequently recurrent infections (relapse or reinfection), or infections associated with urinary tract complications, such as obstruction. Primarily for cystitis, pyelonephritis or pyelitis due to susceptible strains of *E. coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris* and *Proteus morganii*.

NOTE: The increasing frequency of resistant organisms limits the usefulness of antibacterials, especially in these urinary tract infections. The recommended quantitative disc susceptibility method (*Federal Register*, 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted. **Data are insufficient to recommend use in infants and children under 12.**

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions,

BactrimTM DS

(160 mg trimethoprim and 800 mg sulfamethoxazole)

Double Strength tablets

BactrimTM

(80 mg trimethoprim and 400 mg sulfamethoxazole)

tablets

epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, somnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for children under 12. Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) 4 teasp. (20 ml) b.i.d. for 10-14 days.

For patients with renal impairment:

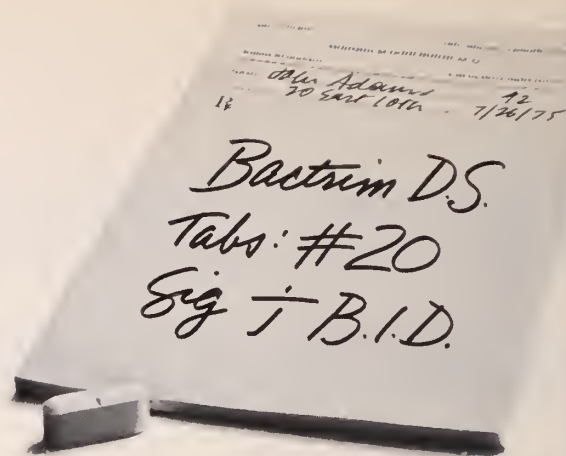
Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) every 24 hours
Below 15	Use not recommended

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole — bottles of 100 and 500; Tel-E-Dose packages of 100; Prescription Paks of 40, available singly and in trays of 10.

Oral suspension, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole; fruit licorice flavored — bottles of 16 oz (1 pint).



Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110



Quality Reassurance

John S. Madara, M.D./Salem*

In this two-hundredth year of our nation's freedom, and the two hundred and tenth year of our Society's existence, it seems fitting to reflect on both our past and our future. Our Medical Society, the oldest on the North American continent, has many accomplishments of which to be proud, yet the predictions of Doctor Benjamin Waddington in his presidential address on June 29, 1910, still ring true. This physician, who was the last member of our Society from Salem County to be honored by this high office said: "The wisdom of today will be the foolishness of tomorrow, the high standards of the now will be the minor height of the then." The goal he set for the future is still our goal — "to study and mayhap some day solve the greatest riddle ever propounded in the universe — the great mysteries of life and death, their origin, possibilities, limitations, how one may be conserved and preserved and the other controlled or deferred." It is interesting that the title of his address to this body sixty-six years ago was "A Plea for a Higher Standard of Medical Education."

There was one quality jealously guarded by the practitioners of his generation which, unfortunately, we in our generation are in danger of losing — the quality that a handful of courageous and daring men, in a moment of danger in 1776, pledged their lives, fortune, and honor to proclaim — *freedom*. The traditional and precious patient-physician relationship is being eroded by third-party interferers (be they governmental, regulatory, private, or public). During my short term on our Board of Trustees, I have seen the necessity for litigation to preserve quality patient care (for example, the need to fight the arbitrary reduction in Medicaid services despite the fact that Medicaid patients were promised first-rate care; the need to fight mandatory certification of patients' admissions by another physician or nurse; the need to fight the reduction in hospital payments by third-party carriers). Still unsolved is the dilemma of how many surgeons are needed to assure optimal

patient care during major surgical procedures. Another is the attempt by well-meaning but ill-informed decision-makers to place mental hospitals under the control of laymen administrators and treat mental illness as a social malady. In many other areas patient-doctor cooperation on a one-to-one basis is being eroded — confidentiality of records, usurpation of medical duties by non-medical personnel, and control of hospital privileges by insurance carriers. May God grant us strength and perseverance in fighting to preserve this most precious quality we celebrate in our Bicentennial year — *freedom!*

There are three other qualities I would like to see the members of our Society retain in the coming years — qualities that are needed for our sanity and success in caring for patients. The first of these is *fun*. The answer to the first question in the shorter Catechism of the Westminster Confession of Faith is: "Man's chief end is to glorify God, and to *enjoy* Him forever." I have been disturbed recently by the number of physicians who say it is no longer a joy being a doctor, who don't really encourage their offspring to take up a medical career, because "it is such a hassle and burden anymore." My answer to them is "Was it ever easy?" We do have more problems, but let us call them challenges. To those in our profession who are dissatisfied with their specialty, my advice is to change it. Just in our little county society, I have seen a good family doctor become a better urologist, an obstetrician-gynecologist switch to industrial medicine and finally to radiation therapy to find himself. I have seen two anesthesiologists give up "passing gas" — one bought a Radio Shack and the other is now a successful family practitioner. I think both are happier and one is richer, and neither is paying high liability fees.

Another way to have fun in our profession is to get involved! There are many opportunities for a

*Inaugural address on the occasion of the author's induction into the presidency of The Medical Society of New Jersey. Presented to the House of Delegates, second session, June 6, 1976, Cherry Hill.

physician to serve besides administering his professional skills. I urge you to participate actively in your county medical society, your state society, the Health Systems Agencies and their subcommittees, the Professional Standards Review Organization, the New Jersey Foundation for Health Care Evaluation, your hospital staff, board of trustees, and committees. One man can't be active in all these areas (although some of us try!).

The reward for getting involved is to get more involved. Robert Frost once said, "The world is full of willing people — some willing to work, the rest willing to let them." To those who are willing to work, the surprises are unbelievable. When I was second vice-president of this Society, I was appointed liaison-representative to the New Jersey Hospital Association. Out of that has blossomed a very pleasant and fruitful relationship, which has led to representation of three states (New York, New Jersey and Pennsylvania) as a Regional Delegate to the American Hospital Association. If you are offered an opportunity to be on a small committee, I urge you to take it. You may like it, and depending on the effort you give it, you may end up as President of this august Society!

The second quality I hope for the members of our profession is *faith*. If politics is the art of the possible, faith is the art of the impossible. This was the foremost quality of the founders of our nation — faith in a Supreme Being, faith in the rightness of their cause, and faith in their fellow-man. We need a similar faith to face our challenges. As for a religious faith, I believe there are more atheists in fox-holes than there are in a profession that deals with the miracle of birth and the mystery of death, and all the day-to-day decisions in between. Many are the physicians who have seen the power of prayer and witnessed the miracles of healing. Again quoting from Doctor Benjamin Waddington, "In past ages, and in all lands, civilized or uncivilized, by some curious coincidence, or chance, the priest and the doctor were one and the same . . . While the mere theorists of moralities remained theologians, the practical ones gradually separated from abstractions, and concreted into the order of the pill and scalpel." In short, "to heal was to do the holy."

Aside from religious faith, we must have faith in the rightness of our cause. If we don't believe in what we're fighting for, we're bound to lose. If it's wrong to be controlled by third parties, let's fight for our rights. If we must go to court to guarantee our freedom, let's be willing to pay for it. If the choice is between what is right and what is expedient, let us not fear the consequences of doing the proper thing at the expense of being unpopular. It might do us well to heed once again the words of Patrick Henry spoken before the second Virginia Convention two centuries ago: "Is life so dear, or peace so sweet, as to be purchased at the price of chains and slavery? Forbid it, Almighty God! I know not what course others may take, but as for me, give me liberty, or give me death."

In addition to faith in what is right, we need to reaffirm our faith in our fellow-men. I have recently been disillusioned by the mistrust we have in each other. More than one of my colleagues has reminded me that among my faults is my naiveté, my failure to see anything bad in others. When I first went to meetings of the New Jersey Hospital Association, I was reminded by some members of our society to look at them with a careful eye — as Confucius once said, "Treat them like a friend, but watch them like an enemy." On the other side, there were some hospital administrators who gleefully enjoyed a saying we saw on a barn while attending a meeting at Lake Placid: "An apple a day keeps the doctor away, if your aim is right." To my surprise I found out that most of their problems were our problems — the areas where we disagreed were few, but definite, and certainly not enough to prevent cooperation in areas where we agreed. I realized the truth in Pope John's deepest conviction that among all men there is more that unites than divides. He believed "there comes a time when every individual is involved in what happens to all the rest." For this reason I would like this feeling of trust to grow this year — especially in our relations with the governing powers of this State and its regulatory bodies, commissioners, and boards. Perhaps good liaison in this area will prevent needless litigation.

The last quality, and the one we need the most, is *feeling*. If there is one cause for the increased

number of malpractice suits in our profession, it is the lack of concern and compassion exhibited by those who are too busy to care. There are still too many internists who would rather listen to a heart than to a patient, too many surgeons who would rather cut than talk, and too many doctors who don't realize that there is a *person* at each end of a stethoscope. Listen to this excerpt from an editorial by Sydney J. Harris in March 1976: "Malpractice suits are less a mercenary than a psychological reaction to the arrogance, vanity, and impersonality of so many medical practitioners. They have risen in direct proportion to specialization, which severs the personal relationship the patients used to have with the old-fashioned general practitioner. When a doctor is a 'corporation,' why not sue it?"

I hear more complaints about a physician's unwillingness to listen or talk to a patient than I do about his medical ability or performance. The greatest compliment I heard recently about a new physician in our area was that "he talked to me as if he cared." That is the quality most needed in this age of specialization, this era of noninvolvement, and this growth of incorporation. I urge you to take time to talk to your patients, listen to what they say. (I recall a professor in medical school who told us ignorant students that if we'd listen long enough to a

patient, he'd tell us what's wrong with him.) Be compassionate and concerned — feel for your patients.

I remember an incident a few years ago when I was school physician and witnessed the performance of a practice teacher in a special class for difficult children. One little black boy who had been mistreated by his parents, left outside on cold days long enough to lose three toes to frostbite — a boy who was very difficult to teach and more difficult to like — came out of his class one afternoon with tears running down his cheeks, and said to his regular teacher, "Guess what — she kissed me!" He had found a person who cared!

I don't recommend that you kiss all your patients, but at least touch them with the hand of kindness, look at them through eyes that care, and be to them a friend.

These are the qualities I wish for you as we start this third century of our nation's existence — *fun, faith, feeling, freedom*. What I've really tried to say was said much better by Micah, the prophet of old, to the rulers of Israel and Judah: "What does the Lord require of you but to do justice, and to love kindness, and to walk humbly with your God."

31 Market Street, Salem

WORKS HOUR AFTER
HOUR AFTER HOUR
AFTER HOUR AFTER
HOUR AFTER HOUR
AFTER HOUR AFTER
HOUR AFTER HOUR
AFTER HOUR AFTER
HOUR AFTER HOUR

Tedral[®] SA

Each tablet contains 180 mg anhydrous theophylline (90 mg in the immediate release layer and 90 mg in the sustained release layer), 48 mg ephedrine hydrochloride (16 mg in the immediate release layer and 32 mg in the sustained release layer); 25 mg phenobarbital.

SUSTAINED ACTION

The special long-acting oral bronchodilator...one tablet provides 12 hours of protection. b.i.d. dosage offers round-the-clock prophylaxis against asthma symptoms.

TEDRAL[®] SA Sustained Action—CAUTION: Federal law prohibits dispensing without prescription. *Indications:* Tedral SA is indicated for the symptomatic relief of bronchial asthma, asthmatic bronchitis, and other bronchospastic disorders. It may also be used prophylactically to abort or minimize asthmatic attacks and is of value in managing occasional, seasonal, or perennial asthma. Tedral SA (Sustained Action) offers the convenience of b.i.d. dosage. Tedral SA is an adjunct in the total management of the asthmatic patient. Acute or severe asthmatic attacks may necessitate supplemental therapy with other drugs by inhalation or other parenteral routes. *Contraindications:* Sensitivity to any of the ingredients; porphyria. *Warning:* Drowsiness may occur. **PHENOBARBITAL MAY BE HABIT-FORMING.** *Precautions:* Use with caution in the presence of cardiovascular disease, severe hypertension, hyperthyroidism, prostatic hypertrophy, or glaucoma. *Adverse Reactions:* Mild epigastric distress, palpitation, tremulousness, insomnia, difficulty of micturition, and CNS stimulation have been reported. *Dosage:* Tedral SA. *Adults*—(average prophylactic or therapeutic dosage)—one tablet on arising and one tablet 12 hours later. Tablets should not be chewed. *Dosage in children under 12* is not recommended because usage has not been established. *Supplied:* Tedral SA. Double-layered, uncoated, coral/mottled white tablets in bottles of 100 (N 0047-0231-51) and 1000 (N 0047-0231-60). Also in unit dose—package of 10 x 10 strips (N 0047-0231-11). Full information is available on request.



WARNER/CHILCOTT
Division, Warner-Lambert Co.
Morris Plains, N.J. 07950

T-GP-52-B/W

Our therapeutic goals in patients with chronic obstructive pulmonary disease include reduction of discomfort and disability, decrease in the frequency and severity of acute exacerbations, and avoidance of hospitalization. Individuality in treatment is essential. The modalities include the avoidance of pollution, adequate hydration, the administration of bronchodilators, chest physiotherapy, appropriate antibiotics, selective use of corticosteroids, and supplemental oxygen therapy. Although a comprehensive program may benefit the individual patient, no single therapy or group of therapeutic modalities have been demonstrated either to retard or to prevent the progression of chronic obstructive airway disease.

Ambulatory Treatment of Chronic Obstructive Pulmonary Disease*

**Joseph W. Sokolowski, Jr., M.D.
Haddonfield**

Chronic obstructive pulmonary disease has been well documented to be a variety of disorders characterized by an irreversible nature associated with progressive deterioration which occurs at a variable rate.¹ There is no known cure for these entities and, to date, no single therapy or group of therapeutic modalities have been demonstrated to either retard or prevent their progression. Therapeutic objectives include: (1) reduction or abolition of discomfort and disability; (2) reduction in the frequency and severity of acute exacerbations; and (3) avoidance of hospitalization. The general rule in the treatment of patients with chronic obstructive pulmonary disease is individualization of therapy.

Avoid Pollution

Our initial step is the avoidance of environmental pollution, particularly that of a personal nature — smoking. Objectively this will result in a decrease in sputum production. The chronic use of tobacco not only is associated with an increase in bronchial secretions, but also with paralysis of the ciliary transport mechanism.²

Hydration

In conjunction with the avoidance of pollution, adequate hydration is essential for the removal of tracheo-bronchial secretions. This operates

through a liquefaction of sputum, which is best accomplished by the oral route with the average daily ingestion of two to three quarts of fluid. The air in the tracheo-bronchial tree is completely saturated with water vapor at 37° C with an approximate value of 53 mg. of water per liter, while room air with a humidity of 20 percent has only five mg. of water per liter. Generally, this additional 48 mg. of water is added in the nasopharynx in the adequately hydrated patient. Hydration may also be accomplished by a pot humidifier which generates either a warm or cool mist. Unless the humidifier is cleaned with a dilute solution of acetic acid at frequent intervals, however, it represents a potential source of infection with a variety of gram-negative organisms including pseudomonas, proteus, and seratia species. The droplet size generated by a humidifier, 10-100 microns, is deposited in the nasopharynx and the major subdivisions of the tracheo-bronchial tree.

Bronchodilators

Alpha or beta adrenergic amines are utilized for the relief of bronchospasm. The former reduce mucosal edema and congestion, while the latter effect bronchial dilatation. The alpha adrenergics have the troublesome side effect of cardiac stimulation. Hence, utilization of the beta

*Read before the Joint Session of the Sections on Chest Diseases, Family Practice, and Medicine, 209th Annual Meeting, The Medical Society of New Jersey, Cherry Hill, New Jersey, June 2, 1975. Dr. Sokolowski is Director, Respiratory Care Services, Our Lady of Lourdes Hospital, Camden.

adrenergics is encouraged. The available agents include isoproterenol (1:200), racemic epinephrine (2.5%) and isoetharine, a selective beta II stimulator. The effect of a nebulized bronchodilator on the patient with chronic obstructive lung disease is an increase in alveolar ventilation. This may be associated with a transient reduction of the level of arterial oxygenation secondary to altered ventilation-perfusion relationships. The bronchodilator should be diluted 10 to 20 fold to minimize its side effects on the cardiovascular system. Nebulized doses as low as 0.4 mg. have been shown to be as effective as 5 mg. doses.³

Oral agents may also be utilized as bronchodilators. These include ephedrine, and the xanthines such as elixir of theophylline or oxtriphylline, a theophylline salt. In addition to the cardiovascular side effects, these drugs produce gastrointestinal symptoms including nausea and vomiting.

Nebulized agents may be delivered by a simple device such as a hand-bulb nebulizer or by a more sophisticated unit such as an intermittent positive pressure breathing apparatus. The former is as efficient and certainly costs far less. In this regard it is pertinent to reiterate the observation of Noehren who cited "in the safety of the automobile it is not so much the machine as the nut behind the wheel that is the determining factor. In inhalation therapy it is the physician responsible for its prescription and application that really determines its effectiveness."⁴

Chest Physiotherapy

The next essential in treatment is chest physiotherapy: specifically, percussion, vibration, postural drainage, and controlled cough. Bronchial secretions serve as a focus of bacterial infection and produce obstruction to air flow and to other secretions in the distal air spaces. Secretions also produce injury to the broncho-ciliary escalator system.

Techniques for the removal of sputum include: lung inflation, with resultant high expiratory flows; adequate hydration to decrease sputum viscosity; gravitational drainage to facilitate the

selective removal of endobronchial secretions; mechanical percussion to augment the effects of gravitational drainage; and manual compression of the thorax, particularly in those patients whose general condition may preclude the maximum utilization of measures previously mentioned. Postural drainage is an effective technique for the dislodgement of pulmonary secretions from the small peripheral airways, where cough may be ineffective, to the larger central airways from which they may be expectorated.

Breathing exercises are encouraged and may represent a therapeutic modality of great significance to the patient, particularly during an acute exacerbation. These exercises emphasize the diaphragm as the major muscle of respiration. From the mechanical point of view it contributes at least 60 percent of the overall efficiency of ventilation. Diaphragmatic breathing exercises attempt to accomplish hypertrophy of the diaphragm and a repositioning of the diaphragm by both an increase in fiber length and an increase in the actomyosin crosslinks.⁵ Physiologic observations variably demonstrate an increase in tidal volume, a decrease in respiratory rate, increased alveolar ventilation, increased arterial oxygenation, and a decrease in the arterial level of carbon dioxide.⁶ Additional breathing techniques may be beneficial. Pursed lip breathing seems to induce slow deep breathing; paced breathing, in which the ratio of breaths to paces is controlled at a level of 1:4 or 1:6 conserves energy. In conjunction with all these techniques, a graded exercise program may be employed. This has resulted in an increase in exercise tolerance and a sense of well being in the patient. In the majority of instances, this seems to be specific to the task with difficulty in translating from one area of physical endeavor to another.

Medication

Antibiotic therapy may be employed in these patients. The antibiotic of choice is tetracycline. Alternatives include ampicillin or erythromycin. The most common indication for their use is an acute exacerbation with conversion of the sputum from a clear colorless material to a purulent yellow, green, or gray material of increased viscosity. Antibiotic prophylaxis may be

considered and individualized for certain patients. This may be administered on a continuous basis, particularly as a form of "winter" prophylaxis between November and March or it may be administered intermittently for 7 to 10 day intervals.

Steroids have resulted in an unpredictable response, but certain patients have a dramatic reversal of their illness with these agents. The most likely candidates for steroid medications are those with the predominant symptom of wheezing, those who have had a response to other bronchodilator agents and those with a personal or family history of atopy.⁷

In conjunction with a graded exercise program, supplemental oxygen therapy may be utilized. Documented physiological effects include an increase in exercise tolerance in selective patients, a psychogenic benefit and a possible improvement in cardiovascular function. The latter is particularly evident in patients with polycythemia and cor pulmonale.

Ancillary therapy would include sodium restriction, digitalization, and the judicious use of diuretics in patients in cardiac failure. In

patients with polycythemia where the hematocrit is greater than 55, phlebotomy may help. Finally, influenza immunization should be utilized on an annual basis because of the increased morbidity and mortality in patients with chronic obstructive pulmonary disease complicated by influenza.

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501 Haddon Avenue, Haddonfield

Trenton: Rooted in History*

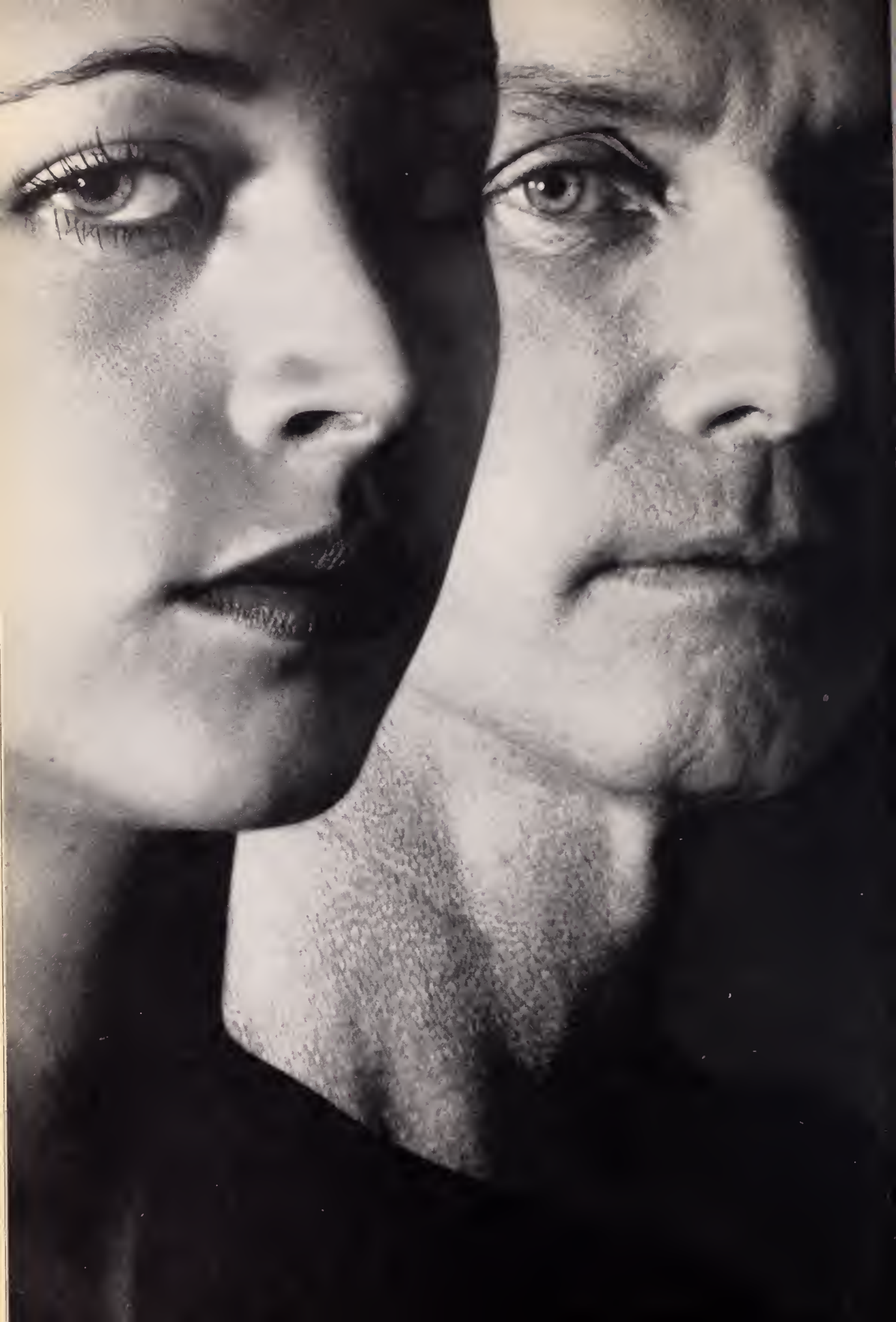
Crossroads of America during the Revolution, center of New Jersey government, and focal point for the State's transportation and industrial growth, Trenton boasts an almost unmatched historical heritage.

The city was settled originally around 1680 and was known initially as "Trent's Town" after leading citizen William Trent who built a magnificent home in the area in 1719. During the 1780's it received serious consideration as the site for the nation's capital. In fact, Congress convened in the city in November 1784. But

Washington was selected instead, and on November 25, 1790, Trenton was chosen as the capital for the state of New Jersey.

With that as a beginning and with the city's crossroad location between New York City and Philadelphia making it a hub for a vast variety of cultural, educational, and industrial activities, Trenton today represents a unique blending of past and present.

*From a brochure, "Touring Historic Trenton" issued by the New Jersey State Museum, Trenton, New Jersey.



Testing in Humans: Who, Where & When.

The weight of ethical opinion:

Few would disagree that the effectiveness and safety of any therapeutic agent or device must be determined through clinical research.

But now the *practice* of clinical research is under appraisal by Congress, the press and the general public. Who shall administer it? On whom are the products to be tested? Under what circumstances? And how shall results be evaluated and sized?

The Pharmaceutical Manufacturers Association represents firms that are significantly engaged in the discovery and development of new medicines, medical devices and diagnostic products. Clinical research is essential to their efforts. Consequently, PMA formulated positions which it submitted on July 11, 1975, to the Subcommittee on Health of the Senate Labor and Public Welfare Committee, its official policy recommendations. These are the essentials of PMA's current thinking in this vital area.

1. PMA supports the mandate and mission of the National Commission for the Protection of Human Subjects of Medical and Behavioral Research and urges to establish a special committee composed of experts of appropriate disciplines familiar with the industry's research methodology to volunteer its advice to the Commission.

2. PMA supports the formation of an independent, expert, broadly based and representative panel to assess the current state of drug innovation and the impact on it of existing laws, regulations and procedures.

3. When FDA proposes regulations, it should prepare and publish in the *Federal Register* a detailed statement assessing the impact of those regulations on drug and device innovation.

4. PMA proposes that an appropriately qualified medical organization be encouraged to undertake a comprehensive study of the optimum roles and responsibilities of the sponsor and physician when company-sponsored clinical research is performed by independent medical investigators.

5. PMA recognizes that the physician-investigator has, and should have, the ultimate responsibility for deciding the substance and form of the informed consent to be obtained. However, PMA recommends that the sponsor of the experiment aid the investigator in discharging this important responsibility by providing (1) a document detailing the investigator's responsibilities under FDA regulations with regard to patient consent, and (2) a written description of the relevant facts about the investigational item to be studied, in comprehensible lay language.

6. In the case of children, the sponsor must require that informed consent be obtained from a legally appropriate representative of the participant. Voluntary consent of an older child, who may be capable of understanding, in addition to that of a parent, guardian or other legally responsible person, is advisable. Safety of the drug or device shall have been assessed in adult populations prior to use in children.

7. PMA endorses the general principle that, in the case of the mentally infirm, consent should be sought from both an understanding subject and from a parent or guardian, or in their absence, another legally responsible person.

8. Pharmaceutical manufacturers sponsoring investigations in prisons must take all reasonable care to assure that the facilities and personnel used in the conduct of the investigations are suitable for the protection of participants, and for the avoidance of coercion, with a respect for basic humanitarian principles.

9. Sponsors intending to conduct non-therapeutic clinical trials through the participation of employee volunteers should expand the membership and scope of its existing Medical Research Committee, or establish such an internal Medical Research Committee, with responsibility to approve the consent forms of all volunteers, designs, protocols and the scope of the trial. The Committee should also bear responsibility to ensure full compliance with all procedures intended to protect employee volunteers' rights.

10. Where the sponsor obtains medical information or data on individuals, it shall be accorded the same confidential

status as provided in codes of ethics governing health care professionals.

11. PMA and its member firms accept responsibility to aid and encourage appropriate follow-up of human subjects who have received investigational products that cause latent toxicity in animals or, during their use in clinical investigation, are found to cause unexpected and serious adverse effects.

12. PMA supports the exploration and development by its member companies of more systematic surveillance procedures for newly marketed products.

13. When a pharmaceutical manufacturer concludes, on the basis of early clinical trials of a basic new agent, that a new drug application is likely to be submitted, a proposed development plan accompanied by a summary of existing data, would be submitted to the FDA. Following a review of this submission, the FDA, and its Advisory Committee where appropriate, would meet with the sponsor to discuss the development plan. No formal FDA approval should be required at this stage. Rather, the emphasis should be on identification of potential problems and questions for the sponsor's further study and resolution as the program develops.

The PMA believes that health professionals as well as the public at large should be made aware of these 13 points in its Policy on Clinical Research. For these recommendations envisage constructive, cooperative action by industry, research institutions, the health professions and government to encourage creative and workable responses to issues involved in the clinical investigation of new products.



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The association of abdominal aortic aneurysm with a horseshoe kidney is rare. Thirty-four cases have been reported in the surgical literature. Two additional patients are now reported. One was discovered at surgery for the aneurysm, and the other detected preoperatively by urography and aortography. The size of the aneurysm, and the number, location, and distribution of the renal arteries compound the complexity of surgical removal. The value of preoperative urography and aortography is stressed.

Abdominal Aortic Aneurysm and the Horseshoe Kidney*

**J. Soriano, M.D., J. Alpert, M.D.,
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D. K. Brief, M.D., and
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Present evidence indicates that the association of horseshoe kidney and abdominal aortic aneurysm is a chance occurrence.¹ Technical difficulties may be encountered in performing the aneurysmectomy since the kidney straddles the aorta and the number, location, and distribution of the renal vessels are variable. Additionally, a preoperative aortogram may have been omitted if the condition was not suspected clinically. A recent experience at the Newark Beth Israel Medical Center with two such patients reconfirms that the surgical approach can both be modified and simplified when preoperative aortograms and intravenous urograms are obtained.

Presentation of Patients

Case 1: A 73-year-old hypertensive man was transferred to the Newark Beth Israel Medical Center for resection of an abdominal aortic aneurysm. Two days before transfer, he had arterial embolization manifested by pain, numbness, and progressive gangrene of the toes of both feet. Examination revealed an elderly thin man in poor general condition. His blood pressure was 160/110 mm Hg., pulse 80/min., and temperature 100.6F. A large, tender pulsatile mass was palpated in the left paraumbilical region. Pulses below both common femoral arteries were absent. Dry gangrene was noted in all toes.

The admission hemoglobin was 12 grams, hematocrit 36 percent, white blood cell 8700, BUN 16 mg/ml, and serum creatinine 1.2 mg/ml. An electrocardiogram showed sinus tachycardia. An abdominal roentgenogram demonstrated linear calcification to the left of the lumbar spine. Neither a urogram nor aortogram was obtained preoperatively.

A classical horseshoe kidney with cystic disease of both superior poles was noted at surgery. The isthmus was

attenuated, fibrotic where it crossed the aneurysm at the aortic bifurcation, and adherent to the anterior wall of the aorta (Figure 1). An anomalous blood supply was not too clearly defined, but it appeared that an anterior renal artery originated directly from the aneurysm and bifurcated to each side of the isthmus. Small renal arteries were identified on both sides. The main left renal vein was normal in size and position. Both ureters were in a lateral position and appeared normal. The aneurysm extended from the level of the main renal arteries, down to and including the aortic bifurcation. Small aneurysms of both common iliac arteries were present.

After the neck of the aneurysm was encircled, further dissection showed additional small renal arteries arising from the aneurysm wall. The inferior mesenteric artery was found proximal to the superior pair of the renal arteries. A small right renal artery was accidentally injured and ligated. To remove the aneurysm, it was necessary to divide the isthmus and sacrifice the renal artery arising from the anterior aortic wall. The divided isthmus was oversewn. The kidneys were then mobilized and retraced laterally allowing resection of the aneurysm. A 22 mm woven bifurcation graft was inserted from the aorta to both common iliac arteries after local endarterectomies. Observation of the kidney for an hour revealed persistent ischemic demarcation approximately 2 cm from each transected end. Further resection was carried out. (Figure 2).

Postoperative oliguria occurred and the BUN rose to 64 mg/ml, and the creatinine to 3.0 mg/ml. After two weeks, both values returned to normal. Bilateral below-knee amputations were later necessary due to the initial embolic insults. A translumbar aortogram six weeks later showed a patent graft with arteriosclerotic changes in the distal iliac and femoral systems. The renal artery was shown to supply the superior kidney with caudally ramifying divisions. The nephrogram phase showed parenchymal defects of the superior and inferior poles suggesting that small renal branches had been interrupted at the sites of the defects.

Case 2: A 70-year-old obese man was admitted for elective resection of an asymptomatic abdominal aortic aneurysm that had been found during a routine physical examination.

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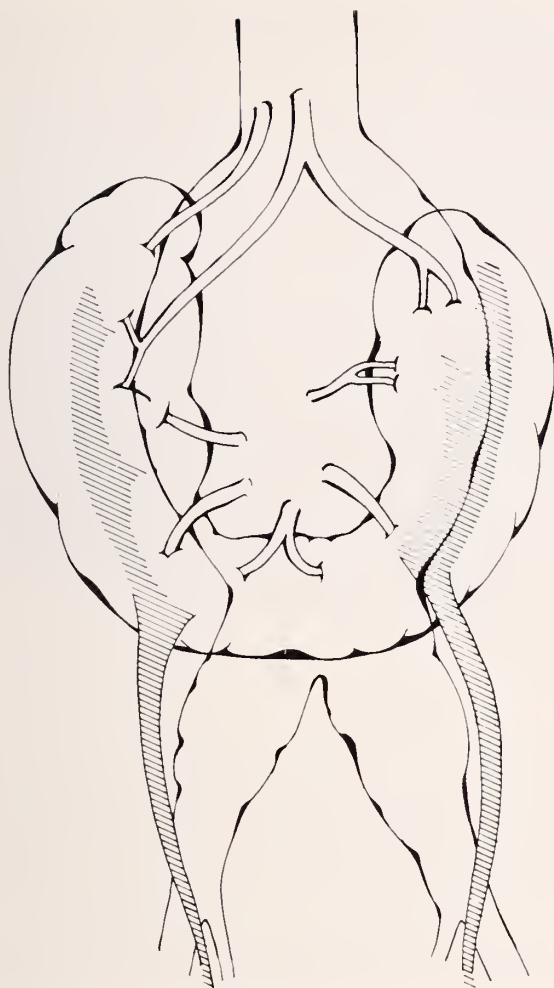


Figure 1 — Patient #1 — Diagram of multiple renal arteries supplying a horseshoe kidney which is anterior to the aneurysm.

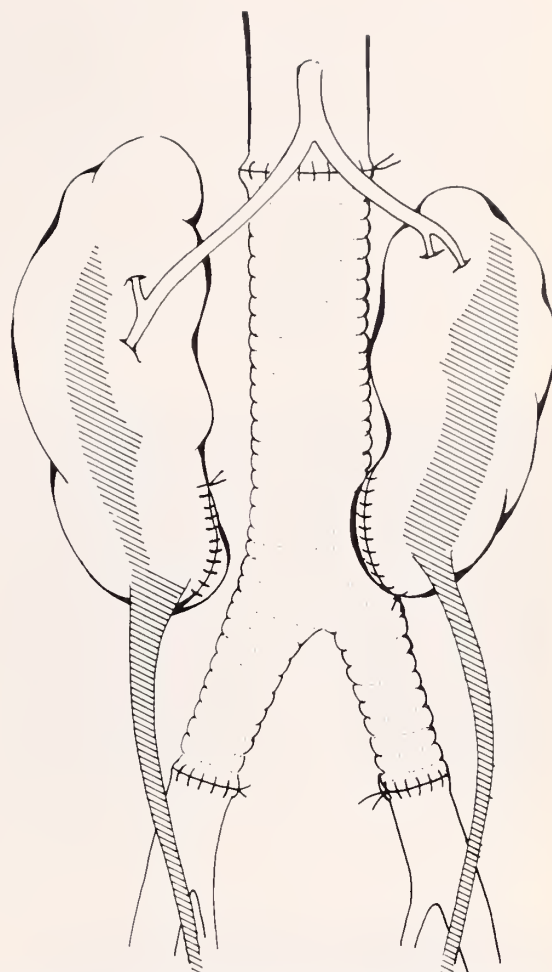


Figure 2 — A single renal artery saved to supply both kidneys following aortic resection and isthmectomy.

A pulsatile, non-tender vague mass was felt in the paraumbilical area. All peripheral pulses were palpable. The BUN was 21 mg/ml. An intravenous urogram demonstrated a typical horseshoe kidney with two normal ureters. (Figure 3). A retrograde aortogram showed the aneurysm with its neck at the level of the isthmus of the kidney. Two pairs of renal arteries were seen, each one supplying the superior and inferior poles of the kidney (Figure 4). The right ureter was anterior and the left lateral.

Laparotomy revealed a moderate-sized abdominal aortic aneurysm arising at the level of the isthmus of a horseshoe kidney and extending to the right common iliac artery. The neck was well below the pair of upper renal arteries. Another pair which originated at the neck supplied the lower pole and the broad isthmus. (Figure 5) The right ureter coursed downwards across the front of the aneurysm, but the left was quite lateral. The inferior mesenteric artery arose between the two pairs of renal arteries. The isthmus was easily mobilized from the anterior aorta and retracted cephalad. No other vessels were noted. The aneurysm was resected leaving a 1.5 cm aortic cuff below the lower paired renal

arteries. Temporary cyanosis of the inferior poles and the isthmus was noted, but disappeared after aortic declamping. A 19 mm woven dacron bifurcation graft was inserted from the aorta to the right external iliac artery and left common iliac artery (Figure 6).

The postoperative course was uneventful. The BUN and creatinine levels remained normal. Ten days later a retrograde aortogram showed patency of the four renal arteries and bifurcation graft with a nephrogram of the horseshoe kidney with ureters (Figure 7).

Comments

A horseshoe kidney may not be clinically detected in the patient with an obvious aortic aneurysm. Consequently, the diagnosis is often missed and can only be made by appropriate x-ray studies or at laparotomy.¹ In 34 previously reported cases² no diagnosis was established by

physical examination alone. Twenty cases were diagnosed by x-ray, and fourteen were recognized at surgery. The association of horseshoe kidney and aneurysm was discovered in three of five unresected cases and seventeen of twenty-nine resected patients. In 20 instances the kidney was not divided and in 11, isthmectomy facilitated surgical exposure of the aneurysm.

Renal vasculature is anomalous in two thirds of patients with horseshoe kidneys.³ One to ten arteries have been described which can arise at

various points from the abdominal aorta (including aneurysms), and the iliac, middle sacral, hypogastric and inferior mesenteric



Figure 3 — Preoperative urogram (Patient #2) showing horseshoe kidney.



Figure 4 — Patient #2 — Aortogram showing 2 pairs of renal arteries with the lower pair arising at the neck of the aneurysm.

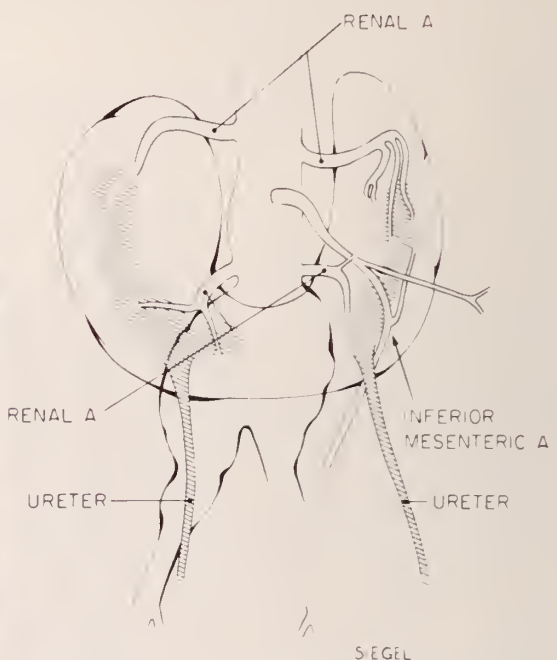


Figure 5 — Patient #2 — Diagrammatic presentation of aortogram.

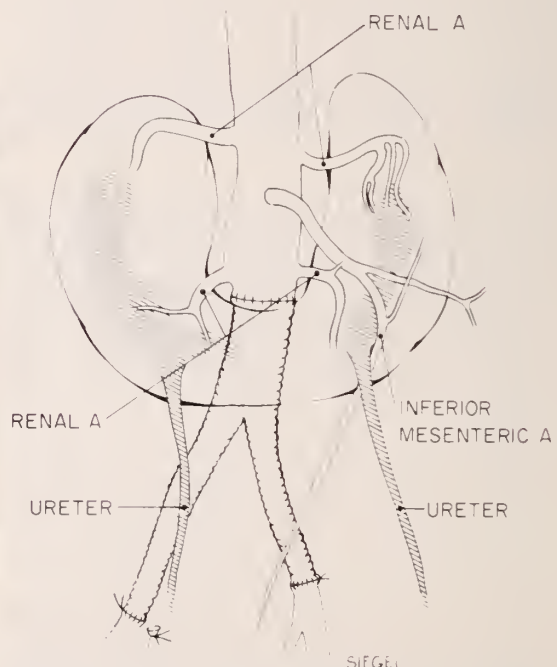


Figure 6 — Artist's view showing preservation of both pairs of renal arteries after aortic resection.



Figure 7 — Postoperative aortogram showing the aneurysmal cuff left to preserve the lower pair of renal arteries.

arteries. These are true end arteries that supply specific segments of the kidney without demonstrable collateral circulation.^{4, 5} The unpredictable arterial supply rather than the anterior fusion of the renal mass accounts for the difficulties encountered at surgery.⁶

Although the reported combination of these entities is limited, knowledge of their coexistence preoperatively allows the surgeon to approach the problem logically. The preoperative identification of the extent of the aneurysm, and the number and location of renal arteries help determine the following:

1. Whether resection can be done with preservation of an adequately functioning renal mass.
2. The extent of resection.
3. The type of anastomosis.
4. The necessity for and method of renal artery reimplantation.

Intravenous urography should be performed routinely on patients with aortic aneurysms and serious consideration given to routine aortography. Although aortography is not necessary to diagnose an abdominal aortic aneurysm, it should be done if a horseshoe

kidney is suspected.⁷ This may reveal the exact renal arterial distribution in all cases,⁸ or the angiographic demonstration may not even conform to the operative findings in some cases.¹ The preoperative identification, however, of the main renal arterial supply (which is usually proximal to the aneurysm) and operative confirmation will assure the surgeon of leaving sufficient viable renal mass should partial resection of the kidney become necessary. (Had this been recognized in the first patient reported, ligation of the proximal small right renal artery might have been avoided.)

Injection of contrast material at several levels in the aorta with oblique and biplanar views help distinguish the renal vessels from those supplying the bowel, adrenals, urinary bladder and lumbar arteries.⁵ The risk of bleeding or dislodging an arteriosclerotic plaque, although minimal should be borne in mind.⁹

In about 90 percent of cases, the isthmus is caudad with its concavity directed cephalad. The isthmus usually lies between the level of L3 to L5. In 5 percent to 10 percent of cases the fusion may be cephalad and the isthmus consists of renal parenchyma, although occasionally it is composed of fibrous tissue bands.¹⁰⁻¹³

The presence of a horseshoe kidney does not always require division of the isthmus. Transection was required in the first patient due to adherence to the aneurysmal wall and to gain access to the aorta. Partial resection of the inferior poles was done at the line of ischemic demarcation. Several authors have found it necessary to do an isthmectomy from which there were no complications.^{2, 8, 14} In two cases reported by Frawley, *et al.* isthmus transection or elevation was not necessary. After proximal resection of the aneurysm and completion of the upper anastomosis, the limbs of the graft were passed through the lumen of the aneurysm.¹

Though unreported, urine drainage from isthmus injury or any part of the collecting system is always of concern, since potential sepsis may be disastrous. Careful isthmus dissection and separation from the aorta can be accomplished for cephalad retraction and access to the aorta (as in the second patient). Once ac-

complished, exploration of the various sites of arterial supply to the kidney is mandatory before aortic resection. Direct observation of renal vessels must be attempted and if not possible, an intraoperative aortogram or selective renal angiogram may be considered.

After restoring aortic continuity, the kidneys must be examined for evidence of ischemia. Partial nephrectomy may be necessary.^{10,17} Transected renal arteries may be re-anastomosed to the prosthetic graft by preserving an aortic cuff with the transected renal arteries. The hypogastric artery can also be used for direct anastomosis.

If one is confronted with this uncommon combination in face of a ruptured aneurysm, there should be no hesitation in sacrificing one or even both kidneys to gain rapid aortic control since immediate transplantation or chronic hemodialysis and later renal transplantation are always feasible for immediate life preservation.

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It is hoped that beclomethasone, by aerosol, will soon be released for clinical use in the United States. Experience in other countries and research studies in the United States indicate that it will be useful in steroid-dependent asthmatic patients. It will enable them to obtain the local benefits of steroids on the bronchial mucosa without deleterious side effects. After three years of clinical trials, no serious side effects have been reported.

Beclomethasone Aerosol for the Steroid-Dependent Patient with Asthma

**M. S. Mattikow, M.D./Wayne and
A. A. Goldfarb, M.D./Teaneck**

Since their introduction into clinical medicine, corticosteroids have proved beneficial in the treatment of patients with asthma who have not been controlled satisfactorily by xanthine derivatives, sympathomimetic drugs or other therapeutic modalities. Effective doses of steroids, however, can lead to undesirable side effects which have limited their use.

Beclomethasone dipropionate to be used with aerosol dispensers will soon be released in this country for clinical use. Reports from other countries and from research centers in the United States indicate that beclomethasone delivered by aerosol overcomes many of the problems encountered in the use of systemic steroids. The purpose of this paper is to acquaint the physician with the advantages and possible disadvantages of this form of steroid therapy.

History

Early clinical experience with oral corticosteroids showed that it was difficult or impossible to wean patients on long-term steroid therapy off the drug. It was also obvious that therapeutic doses sometimes led to suppression of the pituitary-adrenal axis, cushingoid features, weight gain, peptic ulceration, osteoporosis, and growth retardation in children, among other problems.

About 15 years ago, physicians began experimenting with steroids by aerosol on the assumption that a local effect would be possible with

doses small enough to avoid the undesirable secondary systemic effects.¹ In 1960, it was reported that hydrocortisone hemisuccinate powder by aerosol gave some subjective help, but no objective improvement was noted in the double blind study.¹ Later reports described the use of dexamethasone, which has been available in this country for many years as Decadron Respihaler[®].² Further work, showed that symptoms were controlled, but that there was enough Decadron[®] absorbed to suppress the adrenal pituitary axis.³

Beclomethasone

In the intervening years, attempts were made to synthesize newer steroids with greater local effects and less absorption. Beclomethasone (see figure) is one of them. It is 500 times as effective locally on human skin as dexamethasone and yet it is a weak systemic steroid.⁴ In the early 1970's clinical trials using beclomethasone aerosols began to be reported.^{5,6,9,12,13,17}

In 1972, Clark reported results in a study of 17 patients with a follow-up of two to six months.⁵ Nine of the patients had not received steroids prior to the trial of aerosol beclomethasone. Eight other patients took daily doses of 10 to 15 mg. of prednisone. Of the group who previously had not received steroids, all had improvement in their FEV1's^a initially; but in two patients, however, this improvement was not maintained. Plasma hydrocortisone levels, generally remained within normal limits.

^aForced Expiratory Volume in one second.

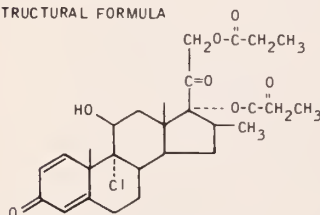
CHEMISTRY

A. GENERIC NAMES: BECLOMETHASONE DIPROPIONATE

B. CHEMICAL NAMES:

1. 9 α -CHLORO-11 β , 17 α , 21-TRIHYDROXY-16 β -METHYLPREGNA-1,4-DIENE-3,21-DIONE 17,21 DIPROPIONATE (ACS NOMENCLATURE)
2. 9 α -CHLORO-11 β -HYDROXY-16 β -METHYL-17 α , 21-DIPROPIONYLOXYPREGNA-1,4-DIENE-3,20-DIONE
3. 9 α -CHLORO-16 β -METHYLPREONISOLONE 17,21 DIPROPIONATE

C. STRUCTURAL FORMULA



D. EMPIRICAL FORMULA $C_{28}H_{37}ClO_7$

E. MOLECULAR WEIGHT: 521.0

F. OTHER PROPERTIES: THE COMPOUND IS A FINE, WHITE POWDER, COMPLETELY TASTELESS AND ODORLESS AND IS ALMOST INSOLUBLE IN WATER.

In those patients who were previously treated with oral steroids, and converted to beclomethasone, the FEV1 (Forced Expiratory Volume in one second) was maintained except for some patients who showed a fall over a 10 to 30 day period. Four of the eight patients in this group required further systemic steroids. All had elevation in their plasma hydrocortisone from low levels to within normal limits within two to three weeks. Patients stimulated with tetra-cosactrin all showed a rise in plasma hydrocortisone.

Another early study of 37 steroid-dependent patients by Brown, *et al.*⁶ demonstrated that 28 patients were able to stop systemic steroids when treated with beclomethasone by aerosol. However, Herxheimer was only able to decrease the requirement for bronchodilators in one of fifteen patients.⁷

An editorial in *Lancet* in 1972 quoted studies showing that aerosol doses of beclomethasone did not suppress the adrenals; the investigators were able to get good results in patients who were not on steroids and also in patients who previously were treated with 10 mg. prednisone orally every 24 hours.⁸ However, patients who received doses of prednisone in excess of 20 mg. daily required a dose of beclomethasone by aerosol large enough to suppress the adrenal glands.

After these initial reports, attempts were made at double blind studies. In 15 patients who were not on steroids, Goddie, *et al.* showed an improvement in FEV1^a, with beclomethasone as compared to placebo treatment over 7 to 14 days.⁹ These authors sought further increase in FEV1^a by raising the dose of beclomethasone beyond 400 micrograms per 24 hours, but failed to accomplish this although adrenal suppression resulted from administration of 1600 micrograms of beclomethasone aerosol per day.

Cryton, *et al.* studied the effects of 400 micrograms of beclomethasone daily as compared to 800 mgs. beclomethasone and placebo.¹⁰ In 108 patients studied over 28 weeks the criteria for success was the ability to drop the dose of systemic steroids by one-half the previous 24-hour dose. Fifty-four percent of all patients had a successful result using beclomethasone by aerosol in a dose of 400 micrograms per 24 hours. However, in patients who previously took more than 16 mg. of prednisone orally over 24 hours, this dose of beclomethasone was successful in only 18 percent; the success rate increased to 57 percent with a dose of 800 micrograms. In patients who previously took less than 15 mg. of prednisone orally, there was no statistical difference between the two aerosol doses.

This study also addressed itself to secondary fungal infections. Although there were no systemic or pulmonary symptoms, the authors showed that *Candida* colonies were grown from the oral mucosa of 45 percent of patients on 400 micrograms and 70 percent of those on 800 micrograms. They concluded that steroid-dependent patients should be given a trial of 400 micrograms per day of beclomethasone by aerosol and, if this doesn't work, 800 micrograms are justified especially if the previous oral prednisone doses were greater than 16 mg. per day.

In an attempt to evaluate local pathology in the lungs after long-term use of beclomethasone, bronchoscopy was performed on 12 patients who had used this drug for six months. Biopsy samples failed to show pathological changes which could be attributed to this method of treatment.¹¹

Another study with similar results to those of Cryton, showed that administration of 400 mg. of beclomethasone by aerosol every 24 hours in 42 adults was sufficient to alleviate the need for oral steroids in 26 patients and permitted reduction in dosage of oral steroids in three patients by 66 percent.¹⁰ Thirteen patients showed no response. The responders had a mean oral prednisone dose prior to beclomethasone by aerosol of 11.4 mg. per 24 hours while the non-responders averaged 19.5 mg. Nine patients who were on oral prednisone experienced symptoms of steroid withdrawal when switched to beclomethasone by aerosol.

Reports of the use of this drug in children have been encouraging. Brown was successful in transferring 15 of 16 patients who had previously been on oral cortico-steroids to the aerosol route with only slight withdrawal symptoms; there was a disappearance of cushingoid features, and a resumption of growth.¹²

Dickson, *et al.* attempted to use the beclomethasone aerosol in 25 children with severe asthma and was successful in 17.¹³ These children were divided into three groups. The first group of nine children was previously on oral doses of steroids that were considered enough to suppress the adrenal pituitary axis. Of these, seven were able to switch successfully to the aerosol drug. The second group consisted of twelve patients who were on lower doses of steroids. In this group, eight benefited from beclomethasone aerosol. The third group was four children who never previously needed oral cortico-steroids and two of these were improved.

Discussion

The long-term care of chronic asthma is the focus of increased study. In the extrinsic asthmatic, avoidance and hyposensitization have proved beneficial, however, in patients with intrinsic asthma drug therapy is often mandatory. Aminophylline and other theophylline derivatives in large enough doses to keep a blood level between 10 and 20 mg/liter is usually effective.¹⁴ Some patients obtain good results using Cromolyn® by inhalation. However, despite active therapy by these oral bronchial dilators and expectorants, oral steroids are occasionally indicated in some severe cases of extrinsic, mixed, and intrinsic asthma. For the group needing

systemic cortico-steroids, beclomethasone by inhalation may prove a successful alternative.

Food and Drug Administration approval to distribute beclomethasone by inhalation is expected. Beclomethasone will be administered by a metered aerosol which will deliver 50 micrograms per puff of a micronized powder which has an average size of five micrometers. The propellants in this inhalator are trichloro fluoromethane and dichloro difluoromethane. The recommended dose is two puffs four times a day for a total of 400 micrograms per 24 hours. This dose is considered equal to 7 mg. of prednisone by mouth per 24 hours.¹⁵ Beclomethasone is said to have a local effect 500 times that of dexamethasone and it is this local effect on the bronchi which is considered its mechanism of action.¹⁶

Although there is evidence that beclomethasone is absorbed from the bronchial mucosa, the total recommended dose for 24 hours appears too small to have any effect on pituitary function; however, three times this dose does have deleterious effects.¹⁷ One should not attempt to lower the dose of oral steroids for at least two weeks after starting beclomethasone; when this is attempted, do it slowly since adrenal insufficiency symptoms may develop. A reduction of no more than 2.5 mg. of prednisone every seven days is probably judicious. Patients on beclomethasone should also be examined for signs of oral or laryngeal fungal infection and should be treated when necessary.

The reported results of aerosol beclomethasone have been impressive but not universal. In many patients only a partial drop in the dose of oral steroids has been possible. Where complete conversion from oral steroids to beclomethasone by aerosol has been possible, a course of oral steroids is often necessary in times of stress (i.e. infection, exposure to allergens, etc.) Other disease symptoms such as nasal polyposis, allergic rhinitis and eczema, which previously were controlled by systemic steroids, often flare up as the patient is weaned off the oral steroids onto the aerosol beclomethasone. This may prove to be a problem in management.

An important warning must be emphasized, however. This experimental drug has been in use

only for approximately three years for a limited number of patients. The final evaluation of its safety can be made only after hundreds of thousands of patients have used it for many more years.

There is no published data as to the long-term effects of its usage on the IgA of the bronchial mucosal surface, or of T cell and B cell activity in the local tissues of the bronchi and lung. Its safety, however, can be evaluated now only as compared to oral steroid usage. It certainly seems a safer medication whenever oral steroid use is mandated.

Summary

It is hoped that beclomethasone, by aerosol, soon will be released for clinical use in the United States. Experience in other countries and research studies in the United States, indicate that it will be useful in steroid dependent asthmatic patients. It will enable them to obtain the local benefits of steroids on the bronchial mucosa without deleterious side effects. After three years of clinical trials, no serious side effects have been reported.

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Two cases of drowning are presented. The pathophysiology and management of such cases are described, and several points made: (1) in near-drowning, the pulmonary status is by far the most important parameter governing survival; (2) immediate emergency resuscitation at the scene is indispensable; (3) all near-drowning victims should be admitted to the hospital intensive care unit and observed for 48 to 72 hours since the incidence of late pulmonary complications is significant; (4) since these accidents occur in places where trained medical personnel normally is not available, training programs for large segments of the lay public should be encouraged and implemented within the state.

Drowning: A Seasonal Nightmare

**H. Stephen Fletcher, M.D. and
Joseph A. Cox, M.D./Livingston***

In the United States some 6,000 souls are the victims of accidental drowning each year. From 1947-1967 there were 110,000 such deaths reported. Many more near-drownings go unreported. This number has been growing yearly due to population mobility and the vast increase in private and municipal pools. The highest incidence of immersion is associated with voluntary sports such as swimming, surfing, or boating in the warmer months. However, a lower, yet appreciable incidence occurs during the colder months with water-associated occupations — accidents on thin ice as well as indoor pool activities.

New Jersey is increasingly vulnerable due to its location on the Atlantic Ocean and its popular seashore resorts. Although no age is exempt, the highest death from drowning occurs in the second decade of life.^{1,2} As many as 35 percent of the drowning victims knew how to swim but exceeded their abilities by "showing off," by overconfidence, or by attempting to swim long distances.³ Alcoholic intoxication has been shown to be a contributing factor in 12 to 14 percent of all accidental drownings. In spite of increased awareness, needless deaths continue to occur due to inadequate training in management of drowning victims with techniques which range from on the spot mouth-to-mouth resuscitation to sophisticated hospital procedures.

Causes of Death in Drowning and Near-Drowning

The events which take place following water

submersion vary with the type of water, the temperature, the state of consciousness, and the general state of health of the victim. Most persons who drown are in good health, although pre-existing cardiac and pulmonary conditions come into play in the elderly. The stages through which 90 percent of drowning individuals progress are listed in Figure 1. The remainder develop laryngospasm before aspiration can

Figure 1

Sequence of Drowning

1. Panic: Violent struggling and automatic swimming movements.
2. Breathholding
3. Apnea
4. Swallowing of large quantities of water.
5. Vomiting
6. Aspiration
7. Convulsions and death.

take place and die of pure anoxia or the "cold immersion syndrome." In this situation prolonged immersion in cold water sufficiently lowers the body temperature to produce cardiac arrhythmias and death. Still others, diving into cooler waters, experience vagal reflexes resulting in immediate cardiac standstill. Drowning implies death, but not all persons who suffer with submersion, whether or not aspiration occurs, die. It must be emphasized that mere survival of the event of near-drowning does not insure ultimate survival. There are many instances of apparent survival where the patient succumbed after several days from pulmonary or neuro-

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logical complications. This mandates close observation and evaluation, as well as vigorous therapy, of all near-drowning victims. Two cases are presented here which serve to illustrate the magnitude of the problem and its management.

Case 1: A five-year-old boy was found on the bottom of a family pool by his brothers after an estimated three to five minutes submersion. He was given immediate mouth-to-mouth resuscitation; he vomited large amounts of fluid. He was conscious during part of the ride to a nearby hospital, but lapsed into unconsciousness. On admission to the hospital he was breathing spontaneously but was noted to have fixed, dilated pupils; he subsequently suffered a respiratory arrest, from which he was successfully resuscitated and intubated.

Laboratory values performed at this time were as follows: Hgb — 10.5 Gm., Hct — 32.0%, WBC — 11,400. Blood Gases: ($F_{I_{O_2}}$ 100%), PaO_2 — 323 torr, pH — 7.21, PCO_2 — 35.3 torr, B.E. — 13.3. Electrolytes: Na — 130 meq/L, K — 4.2 meq/L, CO_2 — 19 meq/L, Cl — 100 meq/L.

At this point the patient was unresponsive so he was transferred by helicopter to St. Barnabas Medical Center for hyperbaric therapy. During the trip by helicopter his pupils were noted to be slightly reactive and he exhibited some thrashing movements. On arrival he responded to deep pain stimuli with a decerebrate posture, although he continued to exhibit thrashing movements.

Chest x-ray on admission to SBMC was clear. Laboratory values were as follows: Hgb — 12.4 Gm, Hct — 35.1%, WBC — 9,800. Electrolytes: Na — 138 meq/L, Cl — 103 meq/L, K — 2.9 meq/L, CO_2 — 23 meq/L. Blood Gases: ($F_{I_{O_2}}$ 100% — 40%), PaO_2 — 100 torr, PCO_2 — 34 torr, pH — 7.48. He had received oxygen during the entire trip by helicopter and on admission to the hospital was placed on a volume respirator and treated with 60 minutes of hyperbaric oxygen at two atmospheres. While in the hyperbaric chamber, he began to respond to deep pain stimuli with thrashing purposeful movements, but was otherwise not responsive. Blood gases at two atmospheres were: ($F_{I_{O_2}}$ 100%), PaO_2 — 761 torr, PCO_2 — 43 torr, pH — 7.39. Following treatment he gradually began to respond and six hours post-chamber treatment he extubated himself and subsequently regained complete consciousness. He exhibited some mental confusion which cleared during the next 24 hours and he was discharged 72 hours following admission, fully recovered, with a normal neurological evaluation.

Case 2: A four-year-old boy, found by a neighbor in a lake after an estimated fifteen minute submersion was given immediate mouth-to-mouth resuscitation. He vomited copious amounts of fluid. He was hospitalized and had a cardiac arrest after admission. After resuscitation the pupils were noted to be fixed and dilated. Placed on a respirator, he was transferred to SBMC. On admission the patient was unresponsive with rigid extremities; the pupils reacted moderately to light and there were rales in both lungs. Chest x-ray was negative.

Initial laboratory findings were as follows: Hgb — 12.7 Gm., Hct — 35.9%, WBC — 15,100; Na — 128 meq/L, K — 2.4 meq/L, Cl — 98 meq/L, CO_2 — 22 meq/L, BUN — 12 mg/dl. Blood Gases were: ($F_{I_{O_2}}$ 100%), PaO_2 — 255 torr; PCO_2 — 27 torr, pH — 7.44, BE — 5.

He was treated in the hyperbaric chamber for 60 minutes at two atmospheres pressure without apparent benefit. Three hours after admission he developed severe pulmonary edema; the condition was diagnosed as "shock lung" and responded to digoxin and furosemide. His neurologic status remained unchanged; 36 hours after admission he developed stress ulcerations and massive gastrointestinal bleeding. This was not controlled so arteriography with perfusion of the superior mesenteric artery with Pitressin® was performed. This controlled the hemorrhage; however, the patient's condition continued to deteriorate. Pulmonary function worsened, renal failure developed, and neurologic dysfunction persisted. He expired 80 hours after the initial submersion.

Pathophysiology and Clinical Findings

Metabolic abnormalities differ when drowning occurs in fresh or salt water. In the former, as in both of our patients, hypotonic water diffuses across the alveolar-capillary membrane rapidly producing hypervolemia and hemodilution with resultant decrease in hemoglobin, sodium, and chloride. Potassium may be increased or normal depending upon the degree of hemolysis taking place. If a significant amount of water is absorbed, pulmonary edema will occur. Ventricular fibrillation has been observed but this is more likely to be due to anoxia rather than the electrolyte abnormalities. Since salt water is hypertonic, fluid diffuses across the alveolar-capillary membrane into the alveoli producing pulmonary edema and hypovolemia.

Most of these changes, which have been observed experimentally in animals, occur in persons who were not resuscitated and die at the scene of the accident. In our experience near-drowning victims do not exhibit significant degrees of electrolyte imbalance upon admission to the hospital and usually do not require meticulous corrective electrolyte therapy. However, patients who survive serious, long immersions in fresh water may have significant degrees of hemolysis which may cause renal complications, possibly requiring hemodialysis. The most important factor in the near-drowning victim is his pulmonary status. As Modell has emphasized,⁴ consciousness upon admission to the hospital does not guarantee survival. Submersion, regardless of the cause or the type of fluid, is always associated with some degree of hypoxia, which may not be evident in the initial blood gas studies since resuscitative techniques at the scene of the accident vary in their effectiveness. The chest x-ray may or may not reflect

atelectasis or pulmonary edema upon admission. All degrees of intrapulmonary shunts have been observed. Furthermore, fresh water submersion alters pulmonary surfactant so that the alveoli are more difficult to distend; this contributes to further pulmonary shunting, which requires positive pressure ventilation therapy.⁵

Depending upon the length of immersion and the degree of anoxia, varying degrees of cerebral damage may be evident. Since it is difficult initially to assess the prognosis especially in children and in patients with altered body temperature, the presence of fixed dilated pupils and other grave neurologic signs should not prevent initial vigorous therapy.

Management

Whether lives are saved or lost depends on what is done for the victim at the scene of the drowning or near-drowning. There is no doubt that immediate discovery and removal from the water with institution of appropriate resuscitative measures offer the best chance of survival. Conversely when an indeterminate period of time has elapsed before discovery and the persons present have no knowledge of resuscitation, chances for survival are greatly diminished. In either event as long as there is any hope, all measures should be taken to save the victim; lives have been salvaged in apparently hopeless situations.⁵

It must be emphasized that in drowning and near-drowning victims, respiratory arrest occurs first. The cardiovascular system is secondarily affected by asphyxia to a degree directly related to the duration of respiratory arrest. Most victims, therefore, require only ventilatory or respiratory resuscitation; a smaller number also require concomitant external cardiac massage.

The rescuer should be sure the airway is not blocked by food, dentures, or other foreign matter and then perform mouth-to-mouth resuscitation. If possible, resuscitation should be carried out with the patient in a head-down position to lessen the chance of aspiration as most victims will vomit large quantities of water. At the beach this may be done by placing the head toward the water. Figure 2 describes the basic steps in mouth-to-mouth resuscitation.

Figure 2

Steps in Performing Mouth-to-Mouth Resuscitation

1. Place victim's head in a "sniffing" position with the neck extended.
2. Clear mouth and throat of food, dentures, or foreign matter.
3. Pinch nostrils closed in adults.
4. Hook thumb of other hand inside mouth behind the mandibular symphysis and lift jaw forward.
5. Keep mouth open slightly and apply lips around orifice blowing with sufficient force to inflate the lungs.

Evacuation to the nearest hospital should be carried out as soon as possible with mouth-to-mouth resuscitative efforts being continued if necessary. At the same time that respiratory support is provided, the cardiovascular status must be ascertained and appropriate cardiac resuscitative efforts initiated, if indicated.

Immediately upon arrival at the hospital emergency room, spontaneous respiratory efforts should be assessed. If needed endotracheal intubation is carried out at this point and mechanical volume respiration with or without positive end expiratory pressure is instituted. A blood sample should be obtained immediately for blood gases, electrolytes, complete blood count, and serum lactate. Most victims will exhibit some degree of metabolic and/or respiratory acidosis, therefore, immediate treatment with sodium bicarbonate is recommended. Chest x-rays should also be obtained in the emergency suite. All near-drowning victims should be admitted to the intensive care unit for observation since late pulmonary complications are not uncommon. One should be aware that initially good arterial oxygen levels and chest x-rays may give one a false sense of security. Antibiotics should be administered prophylactically to treat presumptive aspiration pneumonitis. For the same reason, Solu-Medrol® 30 mg/kg is given early and repeated every four hours for three doses.

A naso-gastric tube should be placed in the unconscious patient. Neurologic status must be evaluated and all patients with depressed neurologic functions should be given Decadron® to help suppress cerebral edema. Central venous pressure and, if possible, pulmonary arterial wedge pressure should be determined. The presence or absence of pulmonary edema should be established. Vaso-active drugs and diuretics may be needed. In fresh water drowning,

hemolysis may precipitate renal failure which will necessitate hemodialysis.

The use of hyperbaric oxygenation may be an effective form of therapy in the presence of anoxic cerebral damage.

In case two no cerebral improvement was noted during the entire hospital course in spite of this therapy. The patient went on to develop further complications, including renal failure and stress ulceration and eventually succumbed. Case one exhibited complete return of function within 48 hours and developed no further complications. Whether this can be attributed to hyperbaric oxygen or the initial resuscitative efforts is a matter for conjecture. Approximately 90 percent of survivors are fully recovered within 72 hours of submersion. A few have late pulmonary complications requiring further intermittent positive pressure. In the case of the awake patient, intermittent positive pressure oxygenation is recommended to combat atelectasis and to help reduce intrapulmonary shunts. As was mentioned previously, in fresh-water drowning there is an alteration in the pulmonary surfactant which renders the alveoli more difficult

to distend. This is not observed with salt water drowning; however, pulmonary surfactant in both cases is washed out so intermittent positive pressure breathing treatment is advocated. Patients should not be discharged from the hospital until all parameters, including neurological and pulmonary function have returned to normal for a 36 to 48 hour period.

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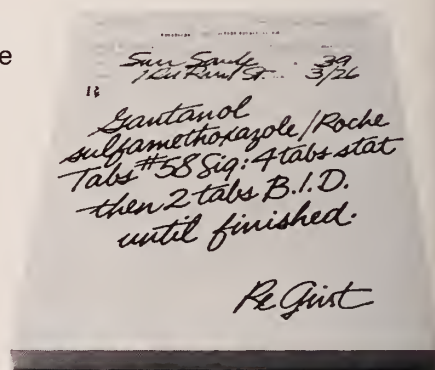
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Warnings: Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-hemolytic streptococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

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The development of adult human sexuality begins at birth and evolves through childhood and adolescence. There are many stages and tasks involved in this process; each must be mastered before the individual can fully develop his or her sexuality. During the sexual act the earlier stages of development are re-experienced. It is possible that the sexual act provides a unique opportunity to regress and to re-experience the pleasures of infancy and childhood.

The Development of Human Sexuality

Larry B. Silver, M.D., Piscataway*

In recent years much has been written on human sexuality, especially that aspect reflected in the sexual act of "love making." Social, cultural, psychological, and physiological views on the stages of this behavior from the initial non-verbal or body language overture to foreplay, climax, and afterplay have been studied. It is interesting to notice that this full cycle from neutrality to climax to neutrality is an encapsulated review of the development of human sexuality. It is but a variation on the basic theme, "ontogeny recapitulates phylogeny."

In tracing the developing sexuality of an individual from early infancy through childhood and adolescence to adulthood, one sees the falling into place of each aspect of the adult sexual act. It is the purpose of this paper to review this development of human sexuality and to illustrate how the stages of adult sexual behavior during the sexual act are brief re-experiences of these developmental stages.

Infancy

The new-born infant is a physiological being, receiving stimuli from all senses and responding. The baby's stomach hurts, he cries; something happens causing the pain to go away, he relaxes and sleeps. Smelling, tasting, touching, and feeling are important sensations. Gradually the infant begins to discover boundaries. He discovers fingers, hands, toes, and feet, and finds that these objects belong to the same body that he has begun to experience. At about three months of life the infant begins to recognize pieces or parts

of the world and relates these "part objects" as important. We see the social smile; the child looks at part of a face and smiles. By about nine months of age most infants have finalized this process, discovering where they leave off and the world begins. They discover that there are many people-objects in the world. By associating certain smells, feels, touches, and tastes with specific people the child learns that among all these objects in his or her world, specific ones are very important. In establishing basic trust in these key objects or people, the infant masters the first major step in development. Parents now find that their child becomes upset if they leave; the child has a fear of separation and a fear of strangers.

These first interactions with the world, leading to the selection of a few trusted and safe individuals on whom to become totally dependent, were first built on smell, taste, and touch, later on vision and sound. Much of these early interactions took place during oral activity with sucking, touching, tongue movements, and exchange of fluids.

As one watches the infant recognize a parent by vision, smell, touch, taste, and/or sound contacts, become motorically excited, react to the body contact, grab for the nipple and suck with a total look of contentment and pleasure on his or her face, it is not difficult to imagine an adult, attracted by a particular smell, glance, touch, sound, or taste, reaching out for body contact,

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beginning such oral activities as kissing, tasting, and touching, then increasing the body contact by holding and caressing.

Early Childhood

By one year of age, most children have established basic trust in significant adults, having become intimately dependent on them for their total emotional and physical well-being. The next task in development is to learn how to separate and to survive without these significant people. The child masters this stage of development in steps.

Initially, at about a year of age, the use of the basic senses as a way of interacting remains important. The child learns to separate as long as there is some type of perceptual hook-up to a significant person. The baby cries, then hears a parent's footsteps in the hall and stops. The auditory linkage was enough. A child crawls behind a chair and loses sight of a parent and cries, then, as the parent moves into view, stops. The visual linkage re-established contact. A baby cries at night, is picked up in the dark and held, and stops; the touch and smell provide reassurance of the needed intimate connection.

Slowly, beginning at about 18 to 24 months, the child learns to separate for longer and longer periods of time. Yet, he must still frequently return to the parent to "refuel." A hug or kiss or cookie will do and they are off again. For some children these early efforts at separating are made easier if something reminding them of the parent can go along. These "transitional objects" are usually selected because they have a familiar smell or soft touch, or cuddly feel that they have learned to associate with the parent.

During this second major stage of development, as the child is trying to master separation, two major psychological events take place. Each helps the child master separation and each helps to shape his developing sexuality.

The first of these issues is "negativism" which begins at age two. Most requests or comments are responded to with a "No . . ." "No, I can do it myself, ma." The child is beginning to try out having a mind of his own. This negativism is an effort toward mastering the separation process.

The other issue occurring at about age two is toilet training. In the process of toilet training the child must learn two new concepts. First, the child must now begin to do things to please others. Love is no longer free and available at his every request. Now, if the child wants love he must do something. Loving relationships are no longer totally centered around the child's wishes and needs but are a give-and-take process. "Make in potty and mommy loves you;" "make in pants and mommy frowns or hits or threatens not to love you."

Prior to this, sexuality meant being loved and feeling safe and secure. Significant relationships were assumed always to be there. All one had to do was call or reach out and all the smells and touches and visions and sounds and experiences appeared. The child must now realize that these significant people do not revolve around his life, just waiting to be available. To get love requires giving. To be pleased requires pleasing. This is a major shift in the child's concept of the world and of people. This essential shift, which must be accepted and mastered before normal development can proceed, markedly shapes developing sexuality.

The second new concept introduced with toilet training is that of having aggressive power. For the first time in a child's life he has an active weapon. Prior to this, the child could cry or have a tantrum but the parents could choose whether to respond or to get angry or not. Now, if the child is angry with the parent he can squat right in front of the parent, preferably when company is around, and with a big smile "make" in his pants. If pleased with mommy or daddy he will "make on the potty." The child must begin to learn what to do with angry feelings.

These issues of wishing to please and be pleased, thus loving and being loved, and of handling angry feelings are struggled with individually and together. The two themes can interrelate, possibly loving and hating the same person at the same time or hurting and caring for the same person at the same time.

Pure narcissism is no more. Being held, feeling warm and safe, sensing total pleasure is no longer there for the demanding. The child learns

that he must give to get, must learn how to please to be pleased, and must deal with those feelings created when one does not get what he wants or needs. Throughout life we seek to recreate this first, ultimate intimate relationship with someone who totally will know our needs and wishes, fully understand, and always be available to respond. Coping with the loss of this world and learning to relate in the new world is an essential step in developing human sexuality.

Childhood

The child has now mastered the first major task of development, establishing basic trust, and the second major task, separating. He must now struggle with individuation; that is, with asking and trying to answer the question, "Who am I?" "Now that I've learned that I am a person and that I can survive without these important people, what kind of a person am I?" These questions are struggled with between about the ages of three and six.

The child begins to try out many roles. What is it like to be big, little, active, passive, a boy, or a girl. They begin to experience what it is like to be female or male. It is during this time that we imprint our cultural stereotypes. If a boy reaches for a doll to play with, he is told that boys do not play with dolls but with guns. This theme is amazing since adult men must know how to relate lovingly to their children and not to use guns. Girls learn that they play with dolls and do things in kitchens; they do not use guns or work with tools in shops. Fortunately, the consciousness-raising efforts of the "women's liberation movement" have helped to free-up these stereotypes. Children should feel free to explore and to learn many roles in becoming a male or female. They should learn that the concept of maleness or femaleness is not based on the kinds of things one does but on the kinds of relationships and respects one develops toward others.

During this stage the child begins to wonder about differences between boys and girls and to notice these differences. While playing "house" or "school" or "doctor" he explores various roles and differences. One day the child is a boy, the next a girl or a mommy or a daddy or a teacher.

The boy may become very affectionate with mother or the girl with father. Their loving glances while cuddling or kissing reflect this affection. They begin to want to have total possession of this significant parent. They begin to learn how to split their parents or to manipulate the environment in order to get this person for themselves. Once again they must deal with love and anger, often with love and anger at the same time.

By age six most children begin to answer the question, "Who am I?" Little boys begin to learn that they are to become "just like daddy" and enjoy playing this role. They give up wanting mommy all to themselves and settle for someday having a girl "just like the girl that married dear old dad." Little girls begin to learn that they are to become "just like mommy" and enjoy playing this role. They give up wanting daddy all to themselves and look forward to some day having someone just like dad.

This first imprinting or establishing of a child's sexuality as a male or a female will be reworked again in adolescence; however, this first learning is the most critical. Basic concepts of masculinity and femininity and of the relationships between the two sexes are to a large part learned from the models provided within the family. It is not unusual to find a woman seeking out a man similar to her father or a man seeking out a woman similar to his mother.

One of the psychological processes that develops at about age six and that assists the child in handling his or her many conflicting feelings and thoughts is the consolidation of various value judgments into a conscience or super-ego. This "voice" of our conscience that remains with us throughout life becomes significant. It "tells" the child what thoughts, feelings, or actions are acceptable or not. Initially, these concepts are taught by one's parents. Later, in adolescence, these value judgments are reconsidered. The early value systems are usually concrete and possibly harsh. If not reworked in adolescence such a super-ego can inhibit or confuse one's sexuality or one's ability to perform sexually.

Late Childhood

Once the child masters this third task of

development, individuation, he or she moves into a period of consolidation. By about age six, the child is free to move out of the family and into the community. With the major psychological work of childhood done, the child's energy is freed up to involve himself in school and learning and in peer relationships.

Earlier learned roles often continue to be reinforced. Boys are taught to play certain games and girls others. Boys do certain activities and girls do others. Boys can dress in certain ways and girls in others.

During this time children begin to focus on relationships with the same sex, often ignoring or moving away from heterosexual peer activities. Boys prefer boys and may not like girls. Girls prefer girls and may avoid boys. Very intimate "chum" relationships develop. Unlike the previous stage, the boy will shrug and push mother away if she wishes to kiss him; and, the girl will feel uncomfortable if father chooses to hold or kiss her. Two girls or two boys may walk down the street arm in arm, the closest of friends. The ability to relate to and form friendships with persons of the same sex is explored and learned.

Pre-Adolescence

It is useful to distinguish between puberty, the physical processes of change, and adolescence, the psycho-social processes of change. Preferably, the two occur simultaneously or close to each other; however, with some individuals either may occur much before the other. When one is out of place with the other the individual has to cope with added stresses.

The pre-adolescent stage usually begins at about the age of eleven to thirteen with girls and twelve to fourteen with boys. Interest in the opposite sex reappears. For many reasons the early adolescent may not return to individuals within the family to explore these new relationships but may look outside the family.

During the early phase of this developmental period, he may continue peer relationships with the same sex; but, the interest shifts. Groups of girls may get together to talk and giggle about boys. Groups of boys may laugh or joke about

girls. Such laughter and jokes become a comfortable way of handling the anxiety created as they begin to re-explore heterosexual feelings and thoughts.

Much as the young child learns to master new tasks and problems through play and through repetition in play; so, the pre-adolescent begins to master his or her new feelings and thoughts through fantasy and play. While reading stories, talking with friends, daydreaming, or making up stories with friends, they begin to explore and to role-play new behaviors and interactions before actually trying.

Through the safety of peer groups of the same sex, they begin actively to re-explore heterosexual interactions. Groups of girls may sit in a booth at an ice cream parlor, laughing about a group of boys across the way. Groups of boys might clown around when near a group of girls. This behavior might lead to group parties or dances and then gradually to individual heterosexual interactions.

Early Adolescence

The individual is now usually physically developing. These bodily changes lead to two conflicting issues and create the first developmental task to be mastered in adolescence, shifting from a dependent to an independent person.

The first result of the physical development is often a loss of self-confidence and a loss of feelings of body mastery. These feelings may lead to the person withdrawing from peer contacts and retreating into the home. He or she is growing in height and weight. Bodily changes such as menarche, breast development, growth of beard and changes in voice occur rapidly. The girl who may have been very graceful and reassured now is clumsy and insecure. The boy who was great in sports and confident is now gangly and uncomfortable. Every day the boy or girl looks into the mirror to see who is there and to readjust.

Although one possible result of the rapid physical development is to increase one's insecurity and thus to increase the wish to retreat

into the safety of the home and family, another aspect of this development may force the individual to move out of the home for relationships and interactions. Unlike the child of three to six whose feelings and thoughts caused conflicts and anxiety, the adolescent has the additional capacity of actions. When a six-year-old boy cuddles in his mother's lap he feels pleasant sensations; but, when the 14-or 15-year-old boy does so, he might realize with embarrassment that he has an erection. A little girl can enjoy the experience of cuddling with her father; but, an early adolescent girl may have concomitant physical sensations or secretions that worry her. Wrestling or tickling a sibling of the opposite sex may become equally stimulating and distressing. This new ability to add actions to the feelings and thoughts is upsetting and may force the adolescent to move such relationships and feelings to individuals outside of the family.

The same is true for angry feelings. It is one thing for a little boy to be angry at his mother as he looks up at her. It is another situation when the angry adolescent realizes that he is taller and bigger than his mother and that he could really hurt her.

Thus, there is conflict. The loss of confidence caused by the physical changes encourages the early adolescent to become more dependent on his home and parents. The maturation of sexual functioning makes it difficult to explore heterosexual relationships again with parents and siblings.

Initially, the early adolescent may attempt to cope by fantasy, choosing relationships with individuals who are unavailable, thus safe. He or she might have a "mad crush" on a movie or record star or on a sports or other hero. The probability of an early adolescent girl suddenly having a rock music star knock at her door and ask for a date is remote enough to allow her to safely fantasize a relationship with him. Gradually, relationships with real, potentially available people are explored. As mentioned earlier, these interactions are likely to be found initially in groups, then smaller groups, and then individually. Early individual dating may be narcissistically-determined. The adolescent

dates someone who makes him or her look good — the cheerleader or football hero. Later, the adolescent will date someone who makes him or her feel good, often someone like the parent of the opposite sex.

The early adolescent must struggle to move from a dependent to an independent person. Often, the initial struggles revolve around the established concepts of sexual roles and identification. Old techniques of mastering separation may be tried again.

Negativism reappears. "No, I can do it myself"; "Don't tell me how long my hair can be"; "Don't tell me how short my skirt can be." Again, the negativism is an attempt to say that he has a mind of his own.

Clothing and hair style have always been favorite issues to prove one's independence. Today, we have the unisex theme; but, every generation has had its "cause." We have had Racoon-Coaters, Beep-Boppers, Zoot-Suiters, Flappers, and so on.

Other issues relating to establishing that the adolescent has a mind separate from his parents may appear. Parents and adolescent may differ on the choice of friends and peer groups, on school plans or courses, on points of philosophy.

All the old struggles with loving and with angry feelings reappear. What do you have to do to be loved or to keep one's love? What do you do with angry feelings? All have to be worked through and in the process shape developing concepts of relationships and of sexuality.

In the process of separating, the adolescent must reject and reformulate his conscience or superego. Unless this is done, the adolescent's parents remain with him in the form of the value systems programed in as a child. Initially the adolescent might reject the former values, pointing out the contradictions or stating that one can't trust anyone over 30. For some, this interim "vacuum," when old values are rejected but new ones have not yet been established, is upsetting. The adolescent might temporarily borrow a "packaged" system. Boy Scout or Girl Scout oaths and laws, religious philosophy and ritual,

or other value systems might be adhered to vigorously. For some, the peer group may provide this interim system. Close "cliques" may set rigid rules about how to dress, whom to talk to, who is in the in-group or out-group or how to behave.

Slowly, the adolescent begins to blend many different value concepts from many sources with his or her existing values. By young adulthood a new super-ego is established. The flexibility and compatibility of this new super-ego will strengthen or inhibit the individual's ability to fulfill his or her adult sexuality.

Middle Adolescence

As the adolescent begins to feel independent of his or her family and the family supports and encourages this emerging maturity, the question of the three to six-year old reappears. Now that I am a separate being, "Who am I?" He or she can no longer be just like mommy or daddy.

Thus, the second developmental task of adolescence begins, establishing one's identity. Becoming a "chip off the old block" is too restrictive. Unlike the child, the older adolescent will select characteristics from many individuals such as religious leaders, scout leaders, teachers, neighbors, relatives, and parents and blend these features with himself to become a unique new person. This new person, or identity, finalizes one's concepts of self. An individual's identity must be reworked throughout life as life roles change; for example, as one becomes a graduate, a spouse, a parent, a grandparent, or a retiree.

Each generation and each culture has different sociological and cultural influences. The child who grew up in the Victorian era would have had different external messages influencing his or her identity than one growing up in the first post-Victorian rebellion, the "flapper stage" of the 20's. So, too, the adolescent growing up today experiences different social and cultural mores and standards than did his or her parents.

The total developmental process that began at birth culminates in this identity. If all previous tasks were successfully mastered, the individual will have a successful functional identity with

healthy and secure feelings about his or her sexuality. If any task or tasks were not successfully mastered, the final identity might be restrictive or dysfunctional.

Late Adolescence

With the developmental task of moving from a dependent to an independent being and of establishing one's initial identity complete, the adolescent has one remaining task to master. Until this time relationships were primarily based on the child-adult model. Now, the adolescent or young adult has to learn how to relate to another individual who is an equal. Erickson^a refers to this type of relating as "intimacy."

When relating in a dependent-independent model one leans on or depends on another, possibly fusing with that person. In an intimate relationship or an independent-independent relationship each becomes intra-dependent on the other. Each leans on and needs the other for his or her emotional well-being; however, at no time does either lose his or her boundaries and at all times each can still stand and function independently.

Discussion

We have traced human sexuality from birth through adolescence and into adulthood. There are many tasks to be mastered and thus many issues which the child might have had difficulty with or might have not fully mastered, leading to a restrictive, inhibited, or dysfunctional adult. Each individual will develop, overdevelop, or underdevelop various stages depending on multiple internal and external factors. Thus, each person grows into a unique adult individual with his or her unique personality.

In many ways the sexual act, from overture through afterplay, is a recapitulation of these developmental stages. The first step is often a particular smell, taste, touch, glance, and/or sound that begins the interest and the possible intimate interaction. During foreplay all of these senses are used. Being caressed, feeling and being felt, oral sensations and pleasures, all add to

^aErikson EH: *Identity and the Life Cycle*. New York, International Universities Press, 1959.

the excitement and sought-after intimate fusion.

The wish to please and be pleased, the need to want and be wanted, the desire to give and to receive, all come into play. Often the blend of love and anger appears as with the "lovebite" or other similar "play."

At the climax there is the ultimate blending and fusing into a total pleasurable experience. During the afterplay one may return to the earlier

behaviors, enjoying being held or touched, being wanted and cared for. There may be the feeling or thought that at that moment in life there is one person who totally cares for and thinks about you. And then, as with the satiated infant, it is off to sleep.

Possibly the sexual act is a unique opportunity to regress and to experience the pleasures of infancy and childhood. Perhaps it is a brief chance to return to home base for refueling.

University Heights, Piscataway

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Treatment Goals for Alcoholics

Earl X. Freed, Ph.D., Lyons

In 1973, decade-old reviews concerning abstinence as a major treatment requisite as well as the main criterion by which to evaluate therapeutic success for alcoholics were updated. This essay called for experimental data, pointed out that strict insistence upon abstinence precluded obtaining such data, and noted that abstinence as a treatment goal probably bespoke a fairly rigid therapeutic attitude. It also indicated that, from a learning theory frame of reference, "the deprivation imposed by abstinence might prove to be counterproductive."¹

The paper evoked many reprint requests and pointed up what a disputatious topic was reviewed. About that time, Miller and Barlow² wrote, "The notion that chronic alcoholics can learn to drink in moderation is a new and controversial one." The review and a companion article by Evans³, "Modification of Drinking," caused an editorial to be written in the same issue of the *Journal of Alcoholism* which concluded that "the wind of change is in fact blowing strongly and we can anticipate an explosion of reports on experimental studies and clinical trials on the modification of drinking in the next few years."⁴

The editor was prophetic as the reports since 1973 in this paper will show.

Trends Since 1973

The trend in the literature appears to be away from citing the "perils of uncontrolled drinking," away from insistence upon sobriety as a *sine qua non*, and away from averring that "no real rehabilitation can take place while alcohol is present in the system."⁵ Neither does the trend appear to be one of pleading for controlled drinking. Rather it seems that

researchers are advocating that treatment choices be available for experimentation and evaluation and that abstinence not be the sole therapeutic objective.^{6,7} The ultimate end of such investigations would seem to be finding the proper treatment goal for each individual patient.^{6,8}

Clearly, there are treated alcoholics who show improvement without total sobriety. Sobell and Sobell⁹ reviewed "more than 60 total studies which have reported that some alcoholic individuals have successfully resumed some type of non-problematic moderate drinking." "Non-problematic" and "drinking" have traditionally represented mutually exclusive concepts for alcoholologists. For example, the first step of Alcoholics Anonymous avers that because of uncontrolled drinking, "our lives had become unmanageable."¹⁰ However, Orford⁸ reported that controlled drinking by treated alcoholic men was possible and that their wives corroborated that such drinking was "acceptable." One year after they had sought therapy, his 100 subjects retrospectively classified those 52 weeks in terms of their drinking behavior as having been abstinent, controlled, or uncontrolled. Of 76 who reported some drinking during the year, only 22 had no weeks of controlled drinking. That controlled drinking existed in the behavioral repertoires of some alcoholics led Orford to suggest that such patients might be the best candidates for the therapeutic goal of controlled drinking because they had already demonstrated a degree of control.

Again, such hypotheses are counter to Alcoholics Anonymous tenets¹⁰: "We admit we are powerless over alcohol" and "The only alter-

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native is to stop drinking completely, to abstain from even the smallest quantity of alcohol in any form." The military had adopted this frame of reference in alcoholism programs but there are hints of recent changes. For example, in one study, total abstinence for a ten-month period was the goal and it was attained by 61 percent of the 38 subjects while 15 drank at least once.¹¹ However, the authors reported a success rate of 89.5 percent according to other criteria¹² and defined success as "productive relative sobriety—patient enjoying family and his own personal existence with no more than two brief drinking episodes." This rate seems relatively high as compared to Bahr's¹³ estimate that about four to ten percent of alcoholics have the capability of developing patterns of normal drinking.

Another military program¹⁴ employed Antabuse[®] with the rationale that patients then had to make a drinking decision only once a day. A third military program¹⁵ defined successful rehabilitation as the "alcoholic must apparently be free from any significant problem with alcohol" during the 60 day period of reassignment to his unit.

The military rehabilitation programs described thus raise a question about the definition of controlled drinking. Drewery¹⁶ saw it as social drinking. However, Stencel¹⁷ pointed out that social pressures to drink often render abstinence (and, one presumes, controlled drinking) difficult to attain. For example, Ruben¹⁵ wrote that Army "cut-rate liquor prices at the officers' club" might foster alcohol abuse.

Such naturalistic environmental contingencies are difficult to control. This is not so in the alcoholism laboratory. Thus, three chronic alcoholics given access to 95 proof alcohol were able to limit their drinking to less than five ounces a day ("moderate" drinking) in order to "earn" access to an enriched environment.¹⁸ Given effective reinforcers, they were able to make good discriminations between contingent and non-contingent periods and to modulate their drinking. Litman¹⁹ has pointed out that a problem clearly is the alcoholic's ability to generalize contingency management in the non-institutional world, "an obstacle which remains to be overcome." In this regard, contingency

management refers to the manipulation of the reinforcers of an alcoholic's drinking, usually in an experimental clinical setting. Unfortunately, this setting frequently differs from the extra-institutional milieu.

There is a recent report²⁰ that some alcoholics have overcome it. Of 98 alcoholics free to drink 40 percent alcohol during a six-week Veterans Administration inpatient treatment program, 55 drank at some time but in amounts ranging down to a total of only two ounces. Thirty-two were "moderate drinkers" whose median daily intake was 3.5 ounces. After discharge, a six-month follow-up of 91 men revealed that 29 percent reported drinking no more than twice a week with 58 of 89 men intoxicated no more than once during the six months. The authors considered the latter "drinking within what could be considered moderate, or socially acceptable, limits." This, of course, becomes an issue of value judgment. It is akin to regarding the treatment goal of abstinence as unyielding or thinking of non-abstinence in terms of "permissiveness."

Notwithstanding value judgments, the amount or the frequency of drinking represented outcome criteria in 80.4 percent of 265 studies of alcoholism treatment reviewed by Emrick.²¹ In terms of outcome rates, 5.8 percent of the subjects exhibited controlled drinking compared to 33.8 percent who were abstinent. In a companion review, Emrick²² reported that many alcoholics can reduce or stop drinking with minimal or no treatment. However, therapy did enhance the probability of reducing the alcoholic's drinking problem. Ornstein²³ has reported post-treatment drinking patterns of 331 alcoholics at three months and one and two years after therapy. While the proportion of those abstaining tended to drop from 27.5 percent to 9.2 percent over time, the improved group stayed fairly constant at around 22 percent. The "Improved" group were "those veterans who may have consumed from as little as one sip of alcohol to such quantities that were still adjudged markedly below their pre-hospital consumption."

Treatment of alcoholism could well profit from the industrial concept of management by objec-

tive which Morrissey²⁴ expanded to management by objectives and results: "a clear and precise identification of objectives or desired results, the establishment of a realistic program for their achievement, and an evaluation of performance in terms of measured results in attaining them." Ewing⁷ took a step in this direction by suggesting that patients participate with their therapists in setting their drinking goals. This would represent a part of their therapeutic commitment. Clearly, the whole thrust of such approaches is to formulate highly individualized treatment plans for alcoholics and to be flexible in modifying these as dictated by outcomes achieved. The implication is that there are options open to patient and therapist.

It seems reasonable to assume that there is no unitary pathogenesis for alcoholism and that there are heterogeneous therapeutic modalities with varying effectiveness. It seems similarly reasonable to explore the possibility that alternative therapeutic goals to total abstinence may be indicated in specific instances for individual alcoholic patients and their respective therapists.

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DOSAGE: Prevention of iron-deficiency anemia—Children and Adults—1 tsp. (5 cc) daily. Treatment of iron deficiency anemia—Children—1 tsp. t.i.d.; Adults: 1 tsp. q.i.d.

SUPPLY: Bottles of 4 fl. oz. and 16 fl. oz.

CASE REPORT

A 34-year-old woman had headache for three days, followed by right hemiplegia with rapid recovery, but more persistent receptive aphasia and apraxia. A small vascular accident, possibly in an early glioblastoma or an expanding intracranial aneurysm, was considered likely. Left carotid angiography showed occlusion, but left vertebral and right carotid transfemoral studies ruled out tumor and aneurysm. Symptoms were then attributed to watershed insufficiency in the left parieto-temporal area. CAT scan seven months later disclosed an area of satellite infarction in the left posterior parietal region.

Internal Carotid Occlusion in a Young Adult

Ira S. Ross, M.D./South Orange*

Many physicians react with surprise to and even with rejection of the possibility of cerebral vascular occlusions in relatively young people. Thirty years ago the author¹ published a report of cerebral vascular occlusions in six patients varying from 25 to 42 years of age. The occluded vessel was thought to be comparable in size to a coronary artery branch. Then, as now, the diagnosis of coronary occlusion in a young person provoked less reaction on the part of medical colleagues than the diagnosis of cerebral vascular occlusion.

The present case concerns the occlusion of a considerably larger vessel: a segment of the internal carotid artery between the bifurcation of the common carotid artery and an area proximal to the anterior choroidal, posterior communicating, and ophthalmic arteries. There was also evidence of additional satellite cortical infarction revealed by computerized tomography.

The common moderate-to-massive cerebral infarct is frequently caused by occlusion of extracranial arteries. Nevertheless, complete occlusion of the internal carotid may occur without symptoms or pathological evidence of cerebral infarction. In his textbook on the pathology of cerebral blood vessels, Stehbens² stated that clinical studies have confirmed the presence of moderate stenosis and even complete occlusion of the large cervical arteries in aging patients, but added that blood flow is likely to be reduced significantly only when the cross sectional area is less than two square millimeters. In a series of 153 cases of complete occlusion of the internal carotid artery in the neck, reported

by Gurdjian, *et al.*,³ nineteen patients failed to show weakness or paralysis of the opposite side at any time and 60 percent had only minimal signs at the onset of their illness. It is rarely possible to study a young person (who is otherwise as free of vascular disorder as was our patient) by four-vessel angiography so soon after an occlusion of the internal carotid artery.

Case Report

A 34-year-old mother of four children first experienced headache on December 13, 1974. The headache continued and was worse on arising until she was hospitalized three days later. That morning, while hanging laundry she noticed weakness of her right arm so that on several occasions the limb dropped. Then, the same extremity flexed forcibly and became limp. She did not lose consciousness but she became totally paralyzed on her right side. When brought by ambulance to the emergency room she was again able to move her limbs. The patient's comprehension was impaired and her speech was not entirely coherent but she was able to sign her own admission certificate.

Neurological examination the evening of admission revealed her pupils to be round, equal, and reactive to light and accommodation. The optic discs were well outlined; retinal vessels were not remarkable and extraocular movements were well performed in all directions without nystagmus. There was no defect of the confrontation visual fields. The lower cranial nerves were entirely normal. Her tendon reflexes were hyperactive on the right but there were no pathological reflexes. Heel to knee coordination was performed with difficulty. She could not carry out more complex commands. She showed perseveration by persistently repeating, "I can't get it all together. I can't get it all together."

Spinal fluid examination disclosed an initial pressure of 150 mm. of water and clear cerebrospinal fluid. The cell count and electrolytes were normal. The filtered fluid was negative for malignant cells. Protein electrophoresis was normal except for low alpha-1 and alpha-2 globulin. X-ray of the skull and chest disclosed no abnormalities. Brain scan was nor-

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462119

mal. Four-projection imaging was performed immediately and one hour following the dynamic cerebrovascular study and no areas of abnormal accumulation of the radio-pharmaceuticals were seen.

The presumptive diagnosis based on the sequence of headache followed by a small stroke with a fair amount of mental confusion and some receptive aphasia was cerebral infarction possibly in an early glioblastoma. For this reason dexamethasone, four mg., four times daily, and papaverine, 120 mg. intramuscularly every six hours, were administered for the first two days of hospitalization. Headache returned when the papaverine was discontinued.

The patient's speech improved but on December 18 she felt pain in the left-sided teeth and discomfort in her left eye up to the left half of her head. Examination showed a left Horner's syndrome with small pupil, enophthalmos and ptosis which persisted.

Left carotid arteriography was considered to be the simplest approach to demonstrate a tumor in the distribution of the left middle cerebral artery. Many specialists prefer the femoral route because of the danger of dislodging an atheromatous lesion in the carotid, but this patient was young and not generally atherosclerotic. The differential diagnosis rested between a vascular lesion in a malignant tumor and an expanded aneurysm with possible small hemorrhage or infarction distal to it. After delay of three days to offset the concomitant cerebral angiospasm, which is so often present when an aneurysm expands, left common

carotid artery angiography was performed by direct puncture. Test injection demonstrated the normal distal common and external carotid artery (Figure 1). There was marked irregular tapering of the internal carotid artery with complete occlusion 3 cm. above the origin of this vessel. There was minimal opacification of the neck portion of the internal carotid artery.

An electrocardiogram, coagulation profile, hemogram, urinalysis, SMA 12/60, electrolytes, and antinuclear antibody tests were normal. BUN was 21.9 mg./dl., and creatinine was 1.0 mg./dl.; cholesterol was 175 mg./dl.

Failure of equipment necessitated a delay in the patient's evaluation, so she was permitted to go home for Christmas day. Re-examination on December 26 showed a residual left Horner's syndrome, slightly increased right-sided reflexes and a definite right Babinski reflex. The patient was re-hospitalized on that day for left transfemoral carotid angiography. This study disclosed a retrograde propagation of the occlusion of the left internal carotid artery to the bifurcation of the left common carotid with excellent collateral circulation (Figure 2). The left occipital artery was quite well filled. Right carotid angiography filled the right middle cerebral artery, both anterior cerebral arteries, as well as branches of the left middle cerebral (Figure 3). These opacified more slowly than the right-sided vessels but filled quite well up to the insular and opercular branches of the left middle cerebral. Angiographically, the left vertebral artery abundantly filled the left middle cerebral via the left posterior communicating artery (Figure 4).



Figure 1 — Left common carotid angiogram six days after stroke. Note irregular tapering involving the internal carotid artery with complete occlusion 3 cm. above the origin of this vessel.



Figure 2 — Left transfemoral carotid angiogram fourteen days after stroke showing retrograde propagation of the occlusion of the left internal carotid artery to the bifurcation of the left common carotid.

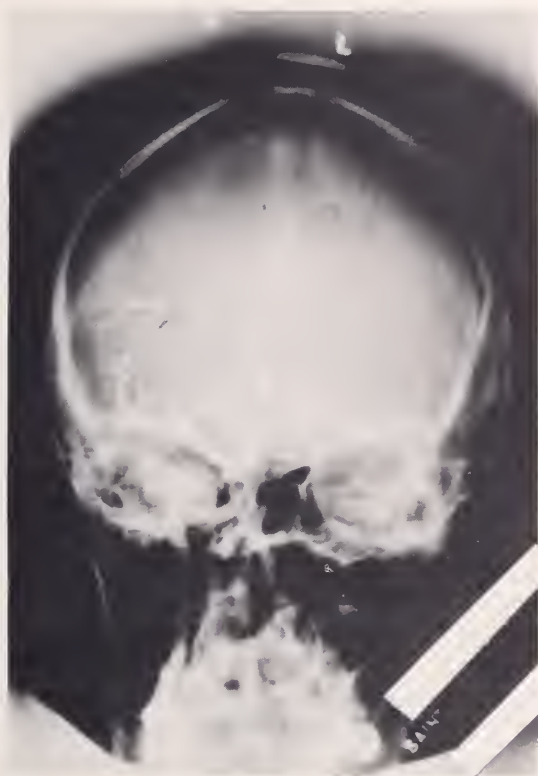


Figure 3 — Right carotid angiogram filling the right middle cerebral, both anterior cerebral as well as branches of the left middle cerebral.



Figure 4 — Angiogram of the left vertebral artery abundantly filling the left middle cerebral.

By January 10 her speech was clear except for minimal hesitancy. She was capable of giving an accurate history of the events of her present illness starting with the initial headache and she was able to return to moderate household activity. Neurological examination showed gait, station, and coordination to be normal; she was able to perform "serial sevens" without mistake, could localize sound stereophonically with her eyes closed and had normal color perception. Re-examination on June 15 disclosed no neurological abnormalities; the patient had resumed full activity and had only occasional difficulty finding a proper word. On July 16 computerized transaxial tomography (CAT†) was per-

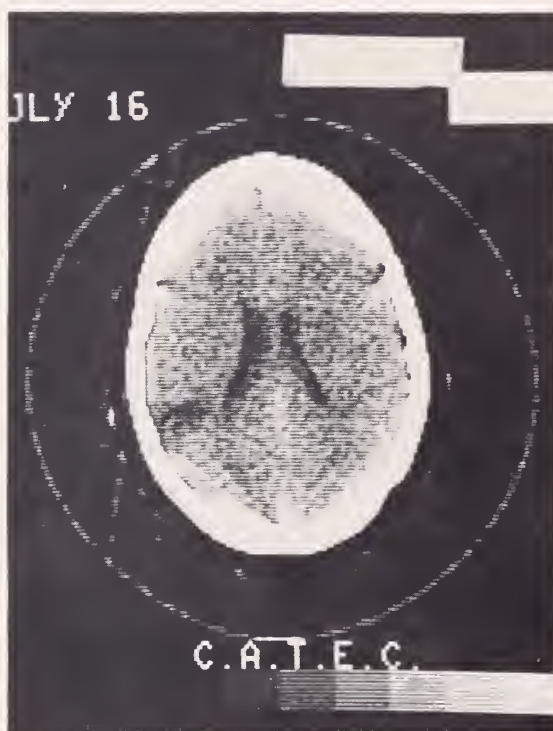


Figure 5 — CAT† scan (July 16, 1975) seven months after stroke showing wedge-shaped area of infarction in left posterior parietal region.

formed (Figure 5). The CAT† study revealed a normal ventricular system, although the body of the left lateral ventricle was slightly larger than the right. In the left posterior parietal region, there was seen a wedge-shaped area of diminished density compatible with an old infarct with no other parenchymal abnormalities.

Thus the CAT† scan disclosed the lesion that produced the patient's symptoms. The evidence indicates that the patient might have sustained the occlusion of the left internal carotid

†The CAT scanner (computerized axial tomograph) is a computerized x-ray device which produces a print-out in diagrammatic numerical distribution. Further processing of these data produces an oscilloscopic picture which can be selectively viewed and photographed. It is a harmless non-invasive technique which may be repeated for serial study since the amount of radiation for eight cross-sectional pictures is approximately equivalent to that used for one conventional x-ray. The instrument comprises a gantry that rotates 180 degrees about the head with a narrow beam of x-ray emitted on one side and a potassium iodide crystal on the other; the crystal picks up the data and transmits these to the computer. The ultimate data are discernible in gradients of a scale in which bone is 500, air is minus 500, and water is zero. The range of information, which permits viewing the brain and ventricles, is roughly zero to forty. Two adjacent slices of either 0.8 cm. or 1.3 cm. wide are taken simultaneously in the span of about five minutes, while the entire study requires 55 minutes. An additional 55 minutes is needed for a repetition using intravenous contrast material if tumors or vascular malformations are suspected.

without any signs were it not for a fragment of clot that found its way to an intrinsic cerebral artery.

Discussion

Gurdjian and associates³ arranged their 153 cases of carotid artery occlusion proved by angiography into three groups according to onset and duration of symptoms and signs: (1) sudden, (2) episodic, (3) progressive. Within each group the patients were divided into five categories:

- (I) Alert with no neurological deficit.
- (IIA) Episodic initial symptoms and signs with reversible neurological manifestations.
- (II) Recurrent or sudden onset with a completed stroke, but with minimal neurological deficit.
- (III) Completed stroke with drowsiness and moderate to severe neurological deficit.
- (IV) Acutely ill with major neurological deficit, completed stroke, and semi-coma.
- (V) Deficit so severe as to produce a moribund state.

Stein and associates, in 1962, performed post-mortem angiography on 130 unselected patients over 50 years of age. Of these, 28 percent had 50 percent or more stenosis of extracranial or intracranial vessels but only nine out of 36 cases had clinical signs. The authors stressed the importance of studying these vessels in the distended state.

Denny-Brown and Foley⁵ and Bauer, Sheehan, and Meyer⁶ stressed the frequent association of hypertension with vascular distortion, atherosclerosis, and vascular tortuosity. Weiner, Berry and Kundin⁷ studied 61 patients with carotid occlusion, only six of whom had no clinical abnormalities. Four of the six had neither anomalous Circle of Willis nor other intracranial or extracranial cerebral vascular occlusion. On the other hand, Groch, Hurwitz, and McDowell⁸ reported on four cases of bilateral carotid artery occlusive disease with little clinical neurological deficit.

Clinical Courses of 153 Patients from Symptom Onset to End of Follow-up (Average 3.7 years)

Clinical Grade at Onset	Number of Patients	A*	I	Clinical Grade at Follow-Up	IIA	II	III	IV	V
I	19	5	2	1	5	4	1	1	
IIA	42	4	2	7	7	14	1	7	
II	31	3	1	0	10	11	4	2	
III	45	1	0	0	11	29	3	1	
IV	13	0	0	0	0	2	5	6	
V	3	0	0	0	0	0	0	3	

*Symptom free.

Patients whose onset of symptoms was sudden had more severe neurological deficits when seen than patients with episodic symptoms but those who survived lived for long periods of time with improvement. Those with episodic cerebral ischemic attacks had more recurrences and did not do as well. Those with progressive onset of symptoms did poorest with completion of stroke an average of 4.5 months after onset and death within one year in 62 percent. Surgically and non-surgically treated patients in Gurdjian's series were not rigorously matched but very little difference was noted in the outcomes of the two groups. The authors stated that vascular surgery is highly unlikely to improve a neurological deficit which has been present more than one week. There is considerable evidence of reversibility with only supportive care.

The frequent autopsy findings of cerebral atherosclerosis in patients dying of other disease entities, with no history or findings of neurological deficit, is too well known to belabor. Other factors have been sought for the occurrence of stroke in addition to atherosclerosis. Cerebral hypotension due to postural effects, carotid sinus reflex, and ectopic paroxysmal cardiac irregularities are often considered. Leff and Nussbaum reported 92 cases of documented myocardial infarction treated in the coronary care unit of Saint Barnabas Medical Center, Livingston (NJ).⁹ Of these 72 had a cardiac arrhythmia, including five patients with primary ventricular fibrillation who survived. Not one of these patients, including those with cardiac arrest, sustained a cerebral infarction. Indeed, Leff stated that not one patient with car-

diac arrest treated at Saint Barnabas manifested stroke upon recovery.¹⁰ What greater hypotensive experience can there be?

Rawles, Ogston, and Douglas considered the relationship of hemostatic factors to thrombosis and concluded that causal relationships of predictive value remain unsubstantiated by clinical trials.¹¹ They say it might be expected that platelet function abnormalities are more likely to be involved in arterial thrombosis, in contrast to abnormalities of coagulation and fibrinolysis in venous thrombosis. It is unlikely, however, that any single hemostatic parameter would be predictive of either arterial or venous thrombosis, since the causation of each is multifactorial and involves platelets, coagulation and fibrinolysis in varying degrees. In addition one must consider the influence of other components of Virchow's triad.**

Ratinov¹² studied the extradural intracranial portion of the carotid artery histologically and found the elastic lamina to be less prominent in the cavernous than in the intrapetrous portion. The calcium content of these vessels is apparently not related to the presence or severity of atherosclerosis. Radiographic correlation was usually found with the degenerative changes present in the intracavernous portion of the internal carotid artery.

Thus, an argument might be made for calcific or atherosclerotic anlage for our patient's thrombosis in the cavernous portion of the internal carotid since she was free of other atherosclerotic change. She had no demonstrable blood dyscrasia, blood pressure abnormality, lymphoma, or intra-arterial vasculitis, but was under a considerable amount of emotional stress. Albano has stated that blood drawn from anxiety-ridden people clots quickly¹³ but this has not been confirmed in the literature. An

emotionally-determined, chemical-clotting enhancer might explain why an atherosclerotic vessel, which has been present for years, chooses a time of stress to clot.

The CAT† scan adds another dimension to the study of stroke. Freshly extravasated blood being of higher absorption density than brain appears whiter on the oscilloscope. As the clot decomposes its image becomes more lucent, so that end-stage encephalomalacia appears darker than surrounding brain. Whereas arteriography displays the intracerebral vascular architecture, the CAT† scan shows the effect of cerebral vascular disease on brain tissue. It was not the carotid occlusion but the satellite infarct that showed in the CAT† scan which explained the patient's symptomatology.

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**Virchow's Triad (1846) is the concept of thrombosis which incorporates alterations in blood flow, in the constituents of the blood, and in the vessel wall. It has not been basically changed to the present time although it is recognized that all three factors need not operate in every incident of thrombosis.

Ref: Virchow, R: Weitere Untersuchungen Über die Verstopfung der Lungenarterie und ihre Folgen. In: *Beiträge zur Experimentellen Pathologie und Physiologie*, ed. Traube, L2. 21 Berlin, A. Foster, 1846.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states, somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

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Following Footsteps

Alton I. Sutnick, M.D., Mary Ellen Hartman, M.D., and
Andrew B. Beasley, Sc.D., Philadelphia*

The past decade has ushered in a variety of factors and forces which have influenced the physician in his role as health care provider. The evolution of the concept of medical care as a universal right has resulted in the assumption by the federal and state governments of a role in the support of care of a significant proportion of its citizens. The possibility, or indeed probability, of national health insurance in the foreseeable future further reinforces the likelihood of federal government intrusion into the physician's traditional relationship with his patient. Patient management is coming under continually increasing scrutiny, with both intra- and extra-professional efforts at quality assurance. Nonetheless, malpractice suits have become a common occurrence and the premium for professional liability insurance has increased in some specialties to the level of their total annual income only a few years ago.

Even within medicine, trends have developed which place greater emphasis on primary care and the health needs of the inner city and rural areas. The family physician has achieved a position as a specialist with the concomitant privations that result from years of clinical training to achieve that goal. He does not know how much of his function will be relegated to nurse practitioners or physicians' assistants as the social changes in medicine progress. There are ever-increasing constraints on the physician's income, and his status in the community has steadily decreased. With the increase in the number of medical schools and the continually enlarging enrollment of existing medical schools, there is a threat of the development of an excess of physicians which could provide an economic crisis for the practitioner. As Groucho Marx once said, "Even the future isn't what it once was."

Those of us who have watched these changes occur are impressed with the growing expectations of society, the uncertainties of bureaucratic control, and the increasing legal

risks. Although unwilling to alter our own commitment many of us are ambivalent about commending its uncertainties to our children.

What effect has this had upon the interest of young people to enter the profession? Have these series of crises in the medical profession influenced the children of physicians to break the tradition of following their parents into the medical ranks?

As can be seen in Figure 1, there has been an enormous, nationwide increase in the number of applicants to medical school,¹ although this now appears to be leveling off or even decreasing. National data are not available on the percentages of either applicants or acceptees who are physician's children, but observations on our own entering class over the past 14 years indicate that, although variations occur from year to year, significant trend changes have not taken place (Figure 2).

NUMBERS OF MEDICAL SCHOOL APPLICANTS NATIONALLY

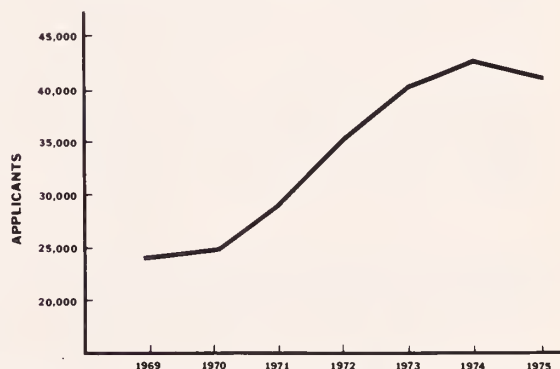


Figure 1 — Total number of medical school applicants in the United States from 1969 through 1975

If we view the men and women who have come to medical school in the last few years as a group, certain sociological factors have in-

*From The Medical College of Pennsylvania, Philadelphia, where Dr. Sutnick is Dean, Dr. Hartman is Associate Dean for Student Affairs, and Dr. Beasley is Assistant Dean for Student Affairs. Supported in part by Grant No. G100 from the Veterans Administration.

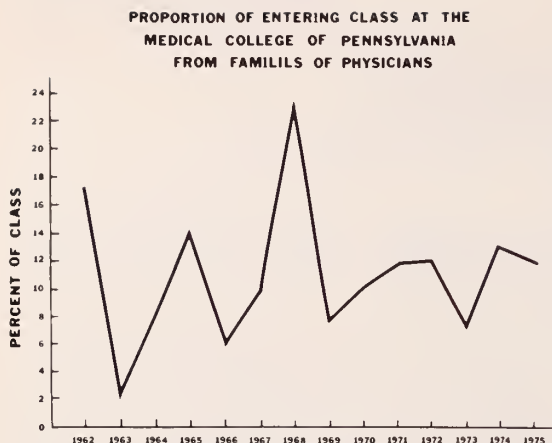


Figure 2 — Proportion of entering class at The Medical College of Pennsylvania from medical families from 1962 through 1975

fluenced their attitudinal development. Unquestionably, they have been the products of an era of affluence whose significant movements have been those of "The Great Society" and "Anti-War." Those social concerns which were humanitarian-based have replaced the "economic survival" issue of the depression era and the "patriotic survival" of the war years. From this comparison one can see that the idealism of this generation has been focused in a somewhat different fashion than that of its predecessors, but has continued to impel them toward humanitarian fields of endeavor such as medicine. The ranks of applicants may have been further swollen in the early seventies by those individuals who were exercising secondary career interests as a result of the withdrawal of governmental support from basic research areas, graduate support, and the space program.

But what trends do we now see developing for the future? It certainly appears that the esca-

tion of the overall pool of applicants has ended. Perhaps the external and internal influences on medical practice are now exacting their toll. Perhaps the attitudes of social consciousness of the under-30 generation are changing. There is also evidence that the number of medical school applicants closely parallels the number of 22-year-olds in the population. Thus the current observations may merely reflect changes in the birth rate several decades ago.²

But the number of highly qualified applicants far exceeds the available places in entering classes and, at least at The Medical College of Pennsylvania, the children of physicians maintain their relative proportion of the class. National data suggest that the proportion of physicians' children among the applicants for the first year class of 1974-75 (11 percent) was slightly lower than the 13-14 percent in previous years.³ At this moment, it is not possible to determine whether this segment of the medical school applicant pool is bending equally to the same influences that are affecting the rest of its generation, or is responding to a perceived underlying satisfaction with the practice of medicine and maintaining a true interest. We hope it is the latter. Only watching developing data will help us to answer that question.

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3300 Henry Avenue, Philadelphia

Dr. Novich — Author and Sports Consultant

Max M. Novich, M.D., orthopedic surgeon from Perth Amboy, was recently appointed a consultant to the President's Commission on Olympic Sports. Dr. Novich was specifically

assigned to the "study of boxing." He also is the co-author of a new book entitled *The High Energy Diet for Dynamic Living*, just published by Grosset and Dunlap.

NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes

May 16, 1976

A regular meeting of the Board of Trustees was held on Sunday, May 16, 1976, at the Executive Offices in Trenton. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

John J. McGuire, M.D. — Memorial Resolution . . . Stood for a moment of silent prayer for John J. McGuire, M.D., President of The Medical Society of New Jersey, who died suddenly on May 3, 1976.

. . . Adopted the following memorial resolution:

John J. McGuire, M.D.
1909-1976

Whereas, after a rich life of distinguished and exemplary service as a renowned physician and outstanding medical leader, John J. McGuire, M.D., our beloved President, suddenly has been called to his eternal reward; and

Whereas, in his years as a member, Doctor McGuire consistently rendered splendid service to The Medical Society of New Jersey as an officer and trustee; and

Whereas, in his medical practice he always exemplified the attributes of a true humanitarian and distinguished physician; and

Whereas, by his ever-present humor and wit he won the affection of all with whom he came in contact; now therefore be it

RESOLVED, that The Medical Society of New Jersey, honoring John J. McGuire in death as in life, records its profound grief at his passing; and be it further

RESOLVED, that a copy of this resolution be spread upon the minutes of this meeting; and be it further

RESOLVED, that this resolution be referred to the House of Delegates to be read at the opening session at the Annual Meeting; and be it further

RESOLVED, that another copy of this resolution, suitably prepared, be presented to his bereaved widow and family, in token of heartfelt sympathy.

. . . Recorded a tribute to Dr. McGuire written by Dr. Madara, which appeared in *The Journal* (73:479), June 1976.

. . . Directed that the customary contribution to the Medical Student Loan Fund be made in honor of Dr. McGuire.

Legislation . . . Approved the recommended positions of the Council on Legislation on the following bills of medical interest, except as noted under S-831, S-1073, and S-1354.

S-10—To permit the courts to require medical or psychiatric treatment or term of imprisonment of up to 3 months for a second offense for operating a motor vehicle while under the influence of alcohol. *APPROVED*

S-34—To create a commission to develop a State plan for the delivery of mental health services and to appropriate \$25,000. *APPROVED*

S-35—To establish a Department of Human Services where the duties shall include development and implementation of comprehensive state plans to provide for continuity of care for all persons requesting and receiving treatment in institutions, agencies and programs under its jurisdiction, including the fullest utilization of available community resources by purchase of care and of service contracts with private agencies and individuals, to transfer various institutions and non-institutional agencies from the Department of Institutions and Agencies and to appropriate \$500,000. *NO ACTION*

S-40—To establish a Department of Mental Health in the Executive branch of government and to appropriate \$100,000. *APPROVED*

S-91—To provide for licensing of social workers. *DISAPPROVED*, because the bill would permit social workers to use medical modalities and therapeutics when they do not have the training, education, or experience to function in such a capacity.

S-93—To authorize the State Board of Higher Education to contract with Fairleigh Dickinson University School of Dentistry for acceptance of New Jersey students. *ACTION DEFERRED*, pending further information from the New Jersey Dental Association.

S-94—To create a commission to study and evaluate the State's institutions, agencies and services for the mentally ill and to appropriate \$25,000. *DISAPPROVED*, because an existing study is currently under way.

S-99—To provide for the licensing of audiologists and speech pathologists. *DISAPPROVED*, because the bill does not provide that the audiologist is to function at the direction or prescription of a duly licensed physician, a factor which is necessary for sound health care plus it is questionable whether licensing would serve any useful purpose.

- S-100*—To amend the Practicing Psychology Licensing Act in several respects concerning the membership on the Board, license fees and continuing education requirements. *ACTION DEFERRED*, pending further information from the Council on Mental Health.
- S-103*—To create a joint underwriting association to provide medical malpractice insurance on a self-supporting basis without subsidy from its members or their policyholders. *NO ACTION*
- S-152*—To define "dwelling" in the law prohibiting the use of lead paint to include day care centers and nursery schools. *APPROVED*
- S-157*—To provide for retention of hospital x-ray films in any size reproductions which maintain the clarity of the original. *NO ACTION*
- S-179*—To require the Commissioner of Insurance to fix a time and place for a hearing upon an application of insurance rate increase or decrease and to give notice to the rating organization of which the applicant is a member and to the Director of the Division of Rate Counsel of the Department of the Public Advocate. *APPROVED*
- S-212*—To provide that nothing in the act concerning Health Care Facilities shall be construed as a delegation of authority to control charges made by health care facilities for services rendered except as otherwise provided. *APPROVED*
- S-213*—To provide that no certificate of need shall be issued or denied without approval of the Board and in the event an adverse recommendation has been issued by the State Health Planning Council, the applicant shall receive notice and be granted an opportunity for hearing. *DISAPPROVED*, because this bill would complicate the effective administration of a law that is presently complicated enough.
- S-215*—To create a guaranteed medical education loan program within the Higher Education Assistance Authority and to appropriate \$50,000. *APPROVED*
- S-220*—To authorize the expenditure of funds for the establishment and maintenance of eye bank facilities and to appropriate \$25,000 for entering into agreements with the New Jersey Eye Bank at the Newark City Hospital. *APPROVED*
- S-222*—To establish a Drug Utilization Review Council which shall prepare a list of interchangeable drug products and to provide that no drug shall be included in the list until after a public hearing and to appropriate \$75,000. *DISAPPROVED*, because no agency at the Federal level has been able to compose a list of therapeutically interchangeable drugs.
- S-262*—To provide that no health care facility shall be operated unless it shall in the case of skilled and intermediate care nursing facilities, establish and maintain a system of discharge planning which assures every patient a planned program of continuing care which meets his post-discharge needs. *NO ACTION*
- S-265*—To require testing of newborn infants for hearing impairments. *NO ACTION*
- S-269*—To provide that a court shall fix the fee for examinations by physicians where testimony is required in an action for injuries or where the mental or physical condition of a party is in controversy. *NO ACTION*
- S-271*—To provide that when an abortion is to be performed after the 20th week of pregnancy, a physician other than the physician performing the abortion shall be in attendance to provide immediate medical care for any live child the result of the abortion, and to authorize the Commissioner of Health to promulgate rules and regulations. *DISAPPROVED*, because the Department of Health already has authorization to promulgate such rules and regulations.
- S-272*—To require nursing homes to assist residents to obtain medically necessary post-discharge aid when their self-pay private insurance or Medicare capability may become sufficiently depleted to necessitate discharge. *NO ACTION*
- S-274*—To prescribe as a misdemeanor the performance of abortions by any method involving the intrauterine injection of a hypertonic solution except where the physician adjudges another method imposes an unreasonable danger to the life of the woman. *ACTIVE OPPOSITION*, because this bill legislates the practice of medicine without proper knowledge of the procedure involved and also because there is no evidence that this procedure, when properly administered, is any more dangerous than any other abortion procedure.
- S-295*—To provide for medical examination of school pupils who may be under the influence of drugs by either the medical inspector or any other doctor. *APPROVED*
- S-297*—To require psychological examinations before persons are appointed to a police department. *CONDITIONAL APPROVAL*, pending amendment of the bill providing that the psychological examination is conducted under the supervision of a psychiatrist.
- S-299*—To authorize the Department of Health to establish programs of rehabilitation for drug-dependent persons, to provide facilities and to provide for licensing operators of such facilities. *DISAPPROVED*, because the legislation is unnecessary in view of the fact that the requested authority already inheres in the Department of Health and is being exercised through the Department's Division of Drug Abuse Control.
- S-304*—To regulate the practice of acupuncture, provide standards, qualifications and certification of practitioners. *NO ACTION*
- S-318*—To provide for the involuntary commitment of persons believed to be mentally ill. *ACTION DEFERRED*, pending further information from the Council on Mental Health.

- S-323—To reduce the penalties for the possession and use of marijuana and hashish. *NO ACTION*
- S-324—To require county mental health boards to create the position of mental health administrator. *ACTION DEFERRED*, pending further information from the Council on Mental Health.
- S-326—To provide that a group health insurer or policyholder shall make forms for filing proof of loss readily available to an insured under a group health program. *NO ACTION*
- S-327—To permit health insurance coverage, other than group and blanket, for outpatient treatment of the mentally ill. *ACTION DEFERRED*, pending further information from the Council on Mental Health.
- S-328—To permit group and blanket health insurance coverage for outpatient treatment for the mentally ill. *ACTION DEFERRED*, pending further information from the Council on Mental Health.
- S-329—To permit hospital service corporations to make available coverage for outpatient treatment of the mentally ill. *ACTION DEFERRED*, pending further information from the Council on Mental Health.
- S-331—To provide for investigation into the deaths and examination of infants under 3 years of age where the suspected cause is sudden infant death syndrome. *NO ACTION*
- S-334—To create a 17-member "New Jersey Drug Abuse Advisory Council" within the Health Department; to repeal the Narcotic Advisory Council in the Department of Institutions and Agencies. *NO ACTION*
- S-336—To establish a personnel screening program in every State and county psychiatric hospital. *NO ACTION*
- S-378—To remove any reference to color and nationality in reporting venereal disease infections, dog bites; to delete requirements and photographs in applications for barbers' licenses and to delete need for specifying color on marriage licenses. *NO ACTION*
- S-476—To provide that any duly incorporated association, organization, league, society or other group created for the purpose of protecting dumb animals shall have the same rights, powers and privileges as are vested in New Jersey Society for Prevention of Cruelty to Animals. *NO ACTION*
- S-485—To prohibit the addition of fluorides to any municipal water supply where total fluorides from all sources in the environment exceed an average of 1.2 milligrams per day per person and to require the Department of Environmental Protection to survey all areas of the State for environmental fluoride content. *ACTION DEFERRED*, pending information from the New Jersey State Laboratory as to the toxic level of fluoride in the water.
- S-487—To include residential health care facility under the Health Care Facilities Planning Act and to direct the Commissioner of Health in consultation with the Commissioner of Institutions and Agencies annually to establish a per diem rate of compensation to be paid to public guests of residential health care facilities. *NO ACTION*
- S-490—To provide that the Commissioner of Insurance shall establish, with the approval of the Health Care Administration Board in the Department of Health, a rate review process for hospitals and institutions and other amendments to the Health Care Facilities Planning Act. *ACTION DEFERRED*, pending further information from the Joint Executive Committee of NJHA and MSNJ.
- S-502—To provide that no person shall be denied eligibility for Medical Assistance and Health Service Act benefits solely on the basis of increased social security benefits payable on or after September 1, 1972. *APPROVED*
- S-515—To exempt employees of a humane society from prohibition of the Controlled Dangerous Substances Act. *APPROVED*
- S-527—To provide that any condition or impairment of health to a uniformed member of a paid fire department caused by hypertension, heart disease or tuberculosis shall be deemed to be an occupational disease. *DISAPPROVED*, because it involves diagnosis by legislative enactment rather than by medical investigation.
- S-538—To require the Commissioner of Insurance to conduct a complete examination of hospital service corporations and hospitals with whom contracted before approving schedules of rates to be paid by subscribers. *ACTION DEFERRED*, pending further information from the Joint Executive Committee of NJHA and MSNJ.
- S-567—To provide that illnesses caused by hypertension, heart disease, tuberculosis, including coronary thrombosis, shall be deemed an occupational disease of fire and policemen. *DISAPPROVED*, because this bill involves diagnosis by legislation rather than by medical examination.
- S-568—To provide under Chapter 253, P.L. 1944 that hypertension, heart disease, tuberculosis suffered by fire and policemen shall be presumed to have been suffered in the line of duty. *DISAPPROVED*, because this bill involves diagnosis by legislation rather than by medical examination.
- S-569—To provide under Chapter 255, P.L. 1944, that hypertension, heart disease, tuberculosis suffered by fire and policemen shall be presumed to have been suffered in the line of duty. *DISAPPROVED*, because this bill involves diagnosis by legislation rather than by medical examination.
- S-599—To provide that the majority of membership on professional boards and commissions shall be public members and that meetings of such shall be open to the public. *DISAPPROVED*, in favor of S-1010.
- S-604—To limit the liability of health care providers for medical malpractice claims and to create a patients'

compensation fund and a Residual Malpractice Insurance Authority. *ACTIVE SUPPORT*

S-610—To provide that it shall be a misdemeanor for a physician to charge excessively higher fees than the normal patient fees for services in workmen's compensation or negligence action claims. *NO ACTION*

S-611—To provide that it shall be a misdemeanor for any physician or surgeon to execute a false medical report which is subsequently submitted to any judicial or administrative proceeding. *ACTIVE SUPPORT*

S-612—To require physicians and surgeons to provide patients with a true, accurate and itemized copy of the bill for treatment rendered where it will be the basis of a legal claim for workmen's compensation or damages in negligence. *NO ACTION*

S-615—To require all group health insurance policies to provide benefits at least equal in value to 60 days hospitalization for mental health illness. *ACTION DEFERRED*, pending further information from the Council on Mental Health.

S-627—To provide that no dentist shall administer a local or general anesthetic unless the State Board of Registration and Examination has certified that he has successfully passed a course in anesthesia or an examination conducted by the Board. *CONDITIONAL APPROVAL*, if reference to the word "local" is deleted.

S-630—To require the State Department of Health to test all newborn infants for phenylketonuria. *NO ACTION*

S-632—Designated "The Catastrophic Illness Assistance Act of 1973"; to authorize program for State assistance, appropriates \$200,000. *APPROVED*

S-637—To establish a State catastrophic health insurance plan, to provide for the certification of health benefits plans as qualified and for the regulations of insurers and providers of health care services and to establish a health resource development fund. *ACTION DEFERRED*, pending further information from the Joint Executive Committee of NJHA and MSNJ.

S-663—To establish the "Long-Term Care, Health Safety and Security Act" to regulate long term health care facilities. *NO ACTION*

S-712—To include central services facilities operated by, rather than serving, institutions within definition of "health care facility" in the Health Care Facilities Planning Act. *NO ACTION*

S-713—To provide for the registration and licensing of electrologists. *NO ACTION*

S-715—To provide for the establishment of medical and dental education programs by the College of Medicine and Dentistry of New Jersey. *APPROVED*

S-717—To include nursing homes and convalescent homes as health care facilities. *NO ACTION*

S-720—To delete certain restrictive provisions in the definition of podiatry under R.S. 45:5-7 permitting the surgical scope of the practice to embrace the entire foot. *ACTIVE OPPOSITION*, because MSNJ does not believe the scope of surgery should be extended beyond what it presently encompasses.

S-721—To permit issuance of limited certificates for x-ray technician in foot radiography. *APPROVED*

S-722—To provide that graduates of accelerated courses in approved colleges of podiatric medicine and surgery shall be eligible for licensure in New Jersey. *APPROVED*

S-724—To provide for the establishment of a Graduate Medical-Dental Education Program to be selected by a newly created Graduate Medical-Dental Education Board and to appropriate \$300,000. *APPROVED*

S-736—To provide for the establishment of a central registry of blood donors in the Department of Health and to appropriate \$50,000. *DISAPPROVED*, because it would be a duplication of record keeping by existing blood banks in the State of New Jersey with no appreciable advantages.

S-742—To authorize the Commissioner of Health to purchase residential and non-residential care and treatment of drug addicts and abusers in non-State facilities. *APPROVED*

S-753—To provide that leaves of absence shall be granted classified civil service employees for the purpose of donating blood. *DISAPPROVED*, because MSNJ strongly supports the voluntary donation of blood. It holds that to grant a donor a day off with pay is to expose him to the same profit motivation that taints commercial blood giving.

S-754—To provide that leaves of absence shall be granted State employees for the purpose of donating blood. *DISAPPROVED*, because MSNJ strongly supports the voluntary donation of blood. It holds that to grant a donor a day off with pay is to expose him to the same profit motivation that taints commercial blood giving.

S-759—To provide that if the weight of alcohol in a defendant's blood is 0.07% or more, it shall be presumed that his ability to operate a motor vehicle was impaired. *APPROVED*

S-804—To exempt from the Sales and Use Tax veterinary prescriptions and drugs, blood and its derivatives. *NO ACTION*

S-819—To require prescription blanks for prescriptions for controlled dangerous substances to be serially numbered with the name of the prescriber printed immediately preceding the number. *DISAPPROVED*, because this bill, due to a lack of an enforceable system of accountability, would be impossible of implementation.

S-831—To provide that the act concerning the practice of medicine and surgery shall not apply to the performance of any act at the direction and supervision of

a licensed physician by a person working under a job description approved by the Board of Medical Examiners and possessing qualifications established by the Board. *ACTION DEFERRED*, because the scope of this bill is too broad and should be restricted.

Note: Board changed Council's position of disapproved to action deferred, pending introduction of a resolution, by the Board, to the House of Delegates requesting that a position either for or against the use of physician-assistants and ancillary personnel be adopted.

S-832—To review the statutory law with respect to consent by minors to performance of hospital, medical or surgical procedures or treatment. *APPROVED*

S-835—To provide that the Department of Health shall prepare lists of family planning clinics in the State together with birth control information pamphlets for distribution by marriage licensing officers. *NO ACTION*

S-836—To define and include "abortion service facility" under the law concerning licensing and regulation of health care facilities. *APPROVED*

S-837—To prohibit profit-making medical referral services. *ACTIVE SUPPORT*

S-838—To limit circumstances under which a report of a referral for abortion services or of an inquiry or request therefor may be furnished. *APPROVED*

S-840—To provide that any person, other than a person licensed to practice medicine and surgery, who performs an abortifacient act shall be guilty of a high misdemeanor. *APPROVED*

S-841—To provide for the preparation and distribution of birth control information in certain cases. *NO ACTION*

S-847—To provide that the procuring, furnishing, donating, processing and distributing of human whole blood, plasma, blood products, human tissue and human organs shall not give rise to any implied warranty and the doctrine of strict tort liability shall not be applicable in any civil action brought in connection therewith. *ACTIVE SUPPORT*

S-851—To provide for the examination of pupils and amending New Jersey Statutes 18A:40-4. *APPROVED*

S-870—To create and establish a risk register for handicapped and high risk children in the Department of Health. *ACTION DEFERRED*, pending further information from the Council on Public Health.

S-882—To permit pharmacists to use discounts or rebates in sales of drugs or medications to disabled persons or those 62 years of age or older. *APPROVED*

S-888—To establish a Division of Consumer Health Services in the Department of Health. *NO ACTION*

S-889—To require physicians to report to the county prosecutor cases of suspected child abuse. *APPROVED*

S-895—To establish a Division of Developmental Disabilities in the Department of Institutions and Agencies. *NO ACTION*

S-896—To establish a Drug Dependence Treatment and Rehabilitation Act. *NO ACTION*

S-902—To authorize the State Board of Pharmacy to give consideration to the geographical needs in granting licenses to applicants and to permit establishment of minimum and maximum prices for prescription drugs. *ACTION DEFERRED*, pending further information from the New Jersey Pharmaceutical Association.

S-903—To provide that physicians, dentists, podiatrists, optometrists and pharmacists who serve as a member of a hospital or extended care facility, hospital medical staff or peer-review committee shall not be liable in damages to any person for any action taken or recommendations made by him within the scope of his function as a member of such committee. *ACTIVE SUPPORT*

S-910—To permit the Board of Higher Education, with the advice and consent of an advisory committee, to enter into contracts with schools of optometry for acceptance of New Jersey students. *NO ACTION*

S-918—To provide for the inclusion of eligible dental expense coverage under the State Health Benefits Program Act. *NO ACTION*

S-942—To provide for unannounced inspections of nursing homes by the Department of Health at least twice a year. *NO ACTION*

S-943—Establishes a Division of Nursing Home Ombudsman within the Department of the Public Advocate; appropriates \$150,000. *NO ACTION*

S-973—To establish a permanent Mental Health Oversight Commission. *ACTION DEFERRED*, pending further information from the Council on Mental Health.

S-976—To prohibit the Department of Environmental Protection from making any rule or regulation directing mandatory fluoridation of a public potable water supply or adjusting the fluoride content. *DISAPPROVED*, because MSNJ is in favor of the mandatory fluoridation of water.

S-992—To provide a definition of death, supplementing Title 24 of the Revised Statutes. *DISAPPROVED*, in favor of S-1039.

S-1005—To permit the advertising of retail prices of prescription drugs. *NO ACTION*

S-1006—To permit optometrists to advertise and to practice optometry in a retail or commercial store or office. *DISAPPROVED*, because the validity of advertising producing lower cost professional services has yet to be established by any responsible source and the concept, if adopted, will increase the costs of goods and services. Further, while permitting optometrists to advertise, this bill would not afford similar rights to ophthalmologists.

- S-1007*—To permit ophthalmic dispensers and technicians to advertise and to require dispensing of eyeglasses within any minimum standards and tolerances as established by the Board of Ophthalmic Dispensers and Technicians. *ACTION DEFERRED*, pending further information from the New Jersey Academy of Ophthalmology and Otolaryngology.
- S-1008*—To reduce the apprenticeship period of ophthalmic dispensers and technicians from 4 to 2 years and to provide that such apprenticeship may be satisfied by completion of an education program beyond high school level approved by the Board of Examiners of Ophthalmic Dispensers and Ophthalmic Technicians. *ACTION DEFERRED*, pending further information from the New Jersey Academy of Ophthalmology and Otolaryngology.
- S-1009*—To reduce from 21 to 18 years the age for admission to an examination for the practice of veterinary medicine and surgery and to provide for completion of satisfactory educational requirements or equivalent experience. *NO ACTION*
- S-1010*—To add a second consumer member to represent the public on the 19 professional and occupational boards under the jurisdiction of the Attorney General and the Real Estate Commission and X-Ray Technician Board of Examiners under jurisdiction of the Commissioners of Insurance and Environmental Protection. *APPROVED*
- S-1011*—To provide for uniform enforcement powers and procedures and standards for revocation, suspension and other disciplinary sanctions for professional and occupational boards within the Division of Consumer Affairs. *DISAPPROVED*, this bill would bypass the professional boards and superimpose the Attorney General into their regular disciplinary role. Currently the Attorney General's office has over 80 cases backlogged and the Division is not in a position to assume further original jurisdiction.
- S-1031*—To establish in the Department of Health a program for the identification, eradication and treatment of Beta Hemolytic Streptococcus infections and to appropriate \$300,000. *NO ACTION*
- S-1033*—To provide a New Jersey Life and Health Insurance Guaranty Association. *NO ACTION*
- S-1039*—To provide general standards for medical determination of death. *APPROVED*
- S-1050*—To exempt registered pharmacists 65 years of age or older from the requirements of the "Continuing Pharmaceutical Education Act." *DISAPPROVED*, because anyone actively involved in dispensing medication or treatment must be current in the practice of their profession.
- S-1073*—To provide for the labeling of prescription drugs showing the ingredients, directions for use, date of issue, name of the patient, the name and address of the furnisher and the strength and quantity of the drugs. *ACTION DEFERRED*
- Note:* Board changed Council's position from approved to action deferred pending discussion of the bill at the MSNJ-NJHA joint executive committee meeting.
- S-1090*—To require physicians, hospitals, dispensaries, asylums or similar public or private institutions to report cases of cancer to the Department of Health. *APPROVED*
- S-1139*—To revise the law regulating the practice of dentistry and dental hygiene. *ACTION DEFERRED*, pending further information from the New Jersey Dental Society.
- S-1161*—To grant physicians or surgeons immunity from liability for services rendered at the request of a police officer in cases involving persons suspected of operating a motor vehicle while under the influence of intoxicating liquor, a narcotic or a habit producing drug. *ACTIVE SUPPORT*
- S-1205*—To amend the "New Jersey State Health Benefits Program Act" to permit the State Health Benefits Commission to purchase certain health care benefits. *NO ACTION*
- S-1213*—Prescribes the nature and extent of training required of emergency mobile intensive care paramedics. *DISAPPROVED*, because the current system operative under the Department of Health is preferable and more protective of the public.
- S-1219*—To define "private nursing facility" and other amendments to the Health Care Facilities Planning Act. *NO ACTION*
- S-1224*—The "County Environmental Health Act"; to provide for establishment of county boards of health to function in all matters concerning environmental health. *NO ACTION*
- S-1231*—To prohibit radiologists from charging patients for interpretation of x-rays applied to a hospital when such service is covered under the patient's hospital insurance contract. *ACTIVE OPPOSITION*, because radiologists like all physicians and professionals have the right to select a fee for service practice. This bill would, if enacted, unconstitutionally deny that right. Further, it conflicts with the enabling act of Blue Cross.
- S-1240*—To fix the Statute of Limitations for personal injury actions at either two years from the date the act allegedly caused the injury or two years from the date the plaintiff discovered the act but in no event later than seven years from the date the act occurred and to provide for tolling these time limitations in any action against a health care provider for fraud, intentional concealment or the presence of a foreign body which has no therapeutic or diagnostic purpose or effect in the injured person. *ACTIVE SUPPORT*
- S-1241*—To establish a period of up to 10 years for actions based on personal injury to persons under 18 years of age. *ACTIVE SUPPORT*
- S-1242*—To define the rights and duties in the physician-patient relationship both inside and outside a health

care facility. *ACTION DEFERRED*, pending recommended changes in the bill.

S-1243—To define the meaning of "informed consent" to a health care procedure. *ACTIVE SUPPORT*

S-1244—To require expert medical testimony concerning deviations from accepted standards in medical malpractice litigation except where a foreign substance was unintentionally left within the body of a patient during surgery or a surgical procedure was performed on the wrong patient, organ, limb or part of a patient's body where a rebuttable presumption shall occur and expert medical testimony shall not be required. *ACTIVE SUPPORT*

S-1245—To provide that a physician having knowledge of medical incompetence shall report such information to the Board of Medical Examiners. *ACTIVE SUPPORT*

S-1246—To authorize the plaintiff in an action for alleged medical negligence to petition the court for a reduction of damages to the extent such costs are paid or payable or indemnified by insurance, governmental employment or service benefit programs. *ACTIVE SUPPORT*

S-1249—To appropriate \$600,000 to the College of Medicine and Dentistry for the South Jersey medical program. *ACTIVE SUPPORT*

S-1265—To provide for reimbursement of an individual who receives Medicaid assistance in the amount of ½ of any attorney's fees he may incur in maintaining an action to establish the legal liability of a third party for care and services arising out of injury, disease or disability. *DISAPPROVED*, the purpose of the Medicaid Program is the provision of health services. This bill would require Medicaid to pay for legal services and thus would drain off monies earmarked for patient care.

S-1309—To declare it the public policy of the State to encourage the development of community mental health programs in order to minimize the need for admissions and readmissions to State and county hospitals. *APPROVED*

S-1324—To provide that general public assistance shall be included in the current State operated medicaid health care benefits program. *APPROVED*

S-1335—To provide for the establishment of a hereditary disorders program. *NO ACTION*

S-1337—To permit minors, who are, or profess to be, afflicted with a venereal disease, to consent to medical procedures where the minor appears to have been sexually assaulted. *APPROVED*

S-1341—To provide that no action may be brought on an agreement or promise of cure relating to medical care or treatment unless such agreement or promise is in writing. *ACTIVE SUPPORT*

S-1342—To establish the Health Care Provider Liability Act concerning civil actions against health care providers and to establish a patient's compensation fund. *ACTIVE SUPPORT*

S-1354—To provide for the registration and regulation of physician assistants. *ACTION DEFERRED*, the need for this type of legislation has not been clearly established, plus the role and function of physician assistants is not definitively described in that direct personal supervision is not required by this proposal.

Note: Board changed Council's position of active opposition to action deferred, pending introduction of a resolution, by the Board, to the House of Delegates requesting that a position either for or against the use of physician-assistants and ancillary personnel be adopted.

S-1357—To require group health insurance policies issued for delivery in New Jersey to provide for home health care. *NO ACTION*

S-1358—To require the inclusion of "home health care" coverage in hospitalization insurance policies and to supplement Chapter 26, Title 17B. *NO ACTION*

S-1360—To permit reimbursement of ½ attorney's fees incurred by Medicaid recipient maintaining certain third party actions. *DISAPPROVED*, the purpose of the Medicaid Program is the provision of health services. This bill would require Medicaid to pay for legal services and thus would drain off monies earmarked for patient care.

S-1361—To permit filing of workers' compensation claim by infant within 2 years after infant's coming of full age. *NO ACTION*

S-1362—To appropriate \$435,903 to South Jersey Medical Program Research, College of Medicine and Dentistry, Camden. *APPROVED*.

... Noted the following bills to be filed:

S-735—To provide that no professional teaching staff member shall use any designation indicating he possesses a doctor's degree unless earned from a college whose degrees are acceptable to the State Department of Higher Education.

S-1290—To require the Commissioner of Health to issue a health officers' license to a duly licensed physician or surgeon with at least 26 years of medical practice and at least 10 years' experience as Director of the Health Department in cities with population of more than 60,000 inhabitants.

SJR-3—To authorize the Director of Motor Vehicles to provide space on all drivers' licenses for information concerning donations under the Uniform Anatomical Gift Act.

SCR-70—To reconstitute the commission to study the feasibility of providing Medicaid assistance for certain handicapped children.

SCR-93—To reconstitute the Special Committee to Investigate Malpractice Insurance costs and availability.

SR-16—To create a commission to study the incidence of cancer in New Jersey.

CPR Certification . . . Approved the report of the Ad Hoc Committee on Cardiopulmonary Resuscitation Certification which addressed the mechanisms for the development of a program for the training of instructors and for establishment of basic training in CPR in hospitals, in accordance with the Standards for CPR and Emergency Cardiac Care, noted in the February 18, 1974, supplement to *JAMA* (227:833-868).

. . . Considered a communication from David A. Gehring, M.D. and directed that he be notified that the Board of Trustees of MSNJ is cognizant of the excellent work he is doing in South Jersey in CPR and that the mechanism described in his communication is currently being developed through the New Jersey Chapter of the American College of Emergency Physicians.

Surgical Assistants . . . Approved the recommendation from the Ad Hoc Committee on Surgical Assistants that called for Board of Trustees' approval of the following proposed revision of the "Rule on Major Surgery:"

(a) Major surgical procedures are those with a hazard to the life, health, and welfare of a patient.

(b) In accordance with the provisions of the Medical Practice Act, N.J.S.A. 45:9-1 et seq, any major surgical procedures with a hazard to life shall be performed only by a duly qualified surgeon with a duly qualified assisting physician, or a duly qualified surgical resident in a training program approved by the Educational Council of the American Medical Association or the American Osteopathic Association, except in matters of dire emergency.

(c) A duly qualified surgeon, duly qualified assistant physician, and duly qualified resident shall be determined by the hospital credentials committee in conjunction with the chairman or chief of the appropriate department or division. It shall be the responsibility of each medical staff to promulgate appropriate rules and regulations in this regard and the medical staff and hospital board of trustees shall assure compliance by the individual physicians.

(d) Failure to comply with this rule may subject the physician to suspension or revocation of his license to practice medicine and surgery in this state, pursuant to N.J.S.A. 45:9-16(g), and/or may subject any other person, association, corporation, or institution to the sanctions and remedies set forth in N.J.S.A. 45:9-22, N.J.S.A. 45:9-26, and N.J.S.A. 45:9-27.1.

Temporary Licenses . . . Directed that Dr. James A. Rogers and Dr. Stanley S. Bergen jointly draft a response to the communication from the State Board of Medical Examiners requesting that, prior to scheduling a meeting

between MSNJ and the State Board of Medical Examiners on the subject of temporary limited licenses, MSNJ's concepts on temporary licensure be forwarded in writing to the Board (of Medical Examiners).

Use of Social Security Number on Medicaid Prescriptions . . . Directed that a communication be sent to the Division of Medical Assistance and Health Services with the suggestion that the physician's license number be the form of identification used on Medicaid prescriptions. (MSNJ previously had requested that the Division not require the use of the social security number on Medicaid prescriptions.)

Medical School Graduates in Underserved Areas . . . Received a report from the Executive Officer of an investigation into the item in the April 24th *Newark Star Ledger* (which stated that upon graduation physicians would be placed, by the medical school, in designated areas) that elicited the following:

(a) Tuition September 1976, will be raised to about \$5100 annually from the current level of approximately \$1500-\$1700. (It should be noted that most private undergraduate schools are charging around \$3500.)

(b) A loan program with an amortization rebate if the student agrees to and does serve in a physician-deficient area of the State. Currently proposed formula would allow loan forgiveness up to 85 percent of indebtedness.

Note: Granting of a loan is not contingent upon the student's willingness to enter the underserved practice agreement.

. . . Directed that the Governor and the members of the New Jersey Legislature be informed that MSNJ is opposed to the drastic increase in tuition for medical and dental students and that they be urged to support increased funding or restored funding for the medical school so that tuition may be lowered to a more appropriate level.

Note: The Dental Society has passed a resolution condemning the tuition on the grounds that it burdens students with tremendous loans and thus makes medical and dental schools available mostly to the wealthy and that the cost of medical care would be increased to enable new physicians and dentists to repay their loans.

Reimbursement for Utilization Review Functions . . . Directed that a response (encompassing the points listed below) be prepared to

the communication from the Commissioner of Health which stated that "the public seems to expect that physicians should perform certain professional services as part of their duties. It would seem that assuring quality medical care and correct treatment of patients is part of the duty . . . and therefore part of their fee . . . I do not believe that physicians are reviewing or are preparing to review for other than Medicare and Medicaid . . . therefore, I do not see the equity of including reimbursement for physician's review in a Blue Cross Rate."

(a) That utilization review committees in hospitals are functioning because of government regulations and third party demands;

(b) That the function of the utilization review committee is purely for cost containment;

(c) That since utilization review committees were established by mandate to assure that governmental and third party funds were being spent properly (and not necessarily to assure quality medical care) and that the ultimate outcome would be a savings to the government, physicians should be reimbursed; and

(d) That physicians have been conducting utilization on Blue Cross cases since the early 1960's prior to the advent of Medicare and Medicaid, or PSRO.

Treatment of Psychiatric Patients . . . Directed that a letter be sent to the Governor, with a copy to the Commissioner of Institutions and Agencies and the medical staff of Ancora Psychiatric Hospital, strongly urging that the Division of Mental Health and Hospitals be removed from the Department of Institutions and Agencies to become an independent department, headed by a physician.

Direct Personal Supervision . . . Directed that MSNJ take a position of amicus curiae and oppose the statement of J. Charles Breme, M.D., Medical Director, Division of Medical Assistance and Health Services, on the definition of direct personal supervision under Medicaid regulations, as it pertains to a court case involving a New Jersey physician's instructions to his nurse to suture a laceration.

Utilization Review Regulations . . . Referred to the New Jersey Delegation to the AMA, for support, a resolution to be submitted to the AMA House of Delegates at the forthcoming meeting in Texas calling for opposition to preadmission certification of elective admissions by hospital utilization review committees as published in the *Federal Register*, March 30, 1976.

Report from the Foundation

Daniel J. O'Regan, M.D., Medical Director

The Board of Trustees of MSNJ, at its meeting of March 21, 1976, voted to endorse the following resolution submitted by this Foundation:

Resolved, that The Medical Society of New Jersey, through the New Jersey Foundation for Health Care Evaluation, in cooperation with representatives of the Component Societies, develop a proposal for the development of one or more IPAs and/or a prepaid health care contract with options.

Those three letters — IPA — stand for Individual Practice Association. This is a form of prepaid health care. The most "visible" form of prepaid arrangement is the Health Maintenance Organization, or HMO. HMOs are springing up in various parts of New Jersey. As an alternative to the closed-panel HMO, with its own facilities, the IPA was suggested by the American Association of Foundations for Medical Care. The IPA concept permits its member-physicians to continue to practice in their own offices. They are paid on a fee-for-services, at risk. For instance, in some areas, the physicians receive 90 percent of their usual fees, with the remaining 10 percent going into a pool, to be shared at the end of the year. There is thus a stimulus to conserve resources by properly utilizing services. How is "properly utilizing" determined? This is done by peer review, which has to be the foundation of any system that offers efficiency of quality medical care. It answers many of the questions and criticisms being leveled at physicians, but it is neither a strict cost control mechanism nor a means of rationing care by limiting access to it. In this day of planners and management, it leaves control in the hands of the professionals — the physicians. It preserves freedom of choice for physician and patient alike. In other words, it comes the closest to preserving the traditional doctor-patient relationship of any "alternative" now under consideration.

Controlling costs with no concern for quality is not in the best interests of physicians and their patients. Developing better access to care is desirable, but not without some rein on costs. Offering a system which provides access, promotes efficiency, and assures quality, through peer review, will be helpful to all concerned. Accessibility, efficiency, quality and peer review — these are watchwords.

Representatives from your component societies, specialty societies, and the New Jersey Association of Osteopathic Physicians and Surgeons have been invited to engage in exploring this concept, in accordance with the resolution. This matter deserves your close attention.

CMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President, CMDNJ

As inexorably as the seasons themselves, two events come around each spring at a medical college: commencement and residency matching.

On June 7, the College granted a record number of 248 M.D., D.M.D., Ph.D., and M.S. degrees to its graduates, 90 percent of whom are New Jerseyans. There were 181 M.D.s, 127 graduates of New Jersey Medical School and 54 from Rutgers Medical School; 61 received D.M.D.s from New Jersey Dental School; and there were five doctorates and one master of science degree from the Graduate School of Biomedical Sciences.

The commencement program itself was inspiring to the graduates, faculty, families, and friends who were privileged to hear David E. Rogers, M.D., the former dean and vice-president of Johns Hopkins School of Medicine, who is now president of The Robert Wood Johnson Foundation of Princeton, probably the world's largest philanthropy dedicated to the health sciences.

The commencement exercise also included conferral of honorary degrees of doctor of science on four highly regarded health care professionals:

Philip J. Boyne, D.M.D., the oral surgeon and dean of the University of Texas Dental School, who developed bone grafting and other surgical techniques.

Harold J. Jeghers, M.D., who established the first department of medicine at the former Seton

Hall College of Medicine, forerunner of CMDNJ.

Gustav O. Lienhard, a former member of CMDNJ's board who is chairman of the board of trustees of The Robert Wood Johnson Foundation.

DeWitt Stetten, Jr., M.D., the first dean of Rutgers Medical School, Piscataway, which, of course, is now part of CMDNJ.

A steadily increasing number of our graduates remain in New Jersey for their residencies. One hundred-twenty new physicians — including those American-born, foreign medical school graduates who received a year's clinical training in our Fifth Pathway Program — chose house staffs of New Jersey hospitals (43 at CMDNJ-Martland Medical Center, our primary teaching hospital in Newark). Last year 97 of our physicians matched with in-state hospitals, the year before, 82, and the year before that, 41. Surely this trend vindicates the faith that went into the founding of CMDNJ!

Distribution of the 122 New Jersey hospital matches was: CMDNJ-New Jersey Medical School, 54; CMDNJ-Rutgers Medical School, 18; and Fifth Channelists, 50. The CMDNJ-Rutgers Medical School number is a new high. This year was the third four-year class to be graduated from the school. Should our proposed teaching hospital materialize on the Piscataway campus it is anticipated a greater portion of that school's graduates will remain in the state.

The other in-state hospitals chosen by our 1976 graduates are: CMDNJ-Raritan Valley Hospital, Green Brook; Cooper Hospital, Camden; Hackensack Hospital, Hackensack; Jersey City Medical Center, Jersey City; Medical Center at Princeton; Monmouth Medical Center, Long Branch; Morristown Memorial Hospital, Morristown; Muhlenberg Hospital, Plainfield; Newark Beth Israel Medical Center; Overlook Hospital, Summit; St. Barnabas Medical Center, Livingston; St. Joseph's Hospital and Medical Center, Paterson; St. Michael's Medical Center, Newark; Somerset Hospital, Somerville; and United Hospitals of Newark.

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Frost & Sullivan has completed a 166-page report (+ appendices) analyzing and forecasting the market through 1985 for these diagnostic product categories: clinical chemistry; hematology; coagulation products; blood banking, serology; microbiology/bacteriology; immunology; histology/cytology; radioassay; and for these special applications: pregnancy tests and urine applications. By test procedure, sales of reagents, test kits and related items for the leading 4-10 suppliers are determined; leading products are described, including pricing; and, where appropriate, sales trends and test popularity are determined. On an overall basis, the leading companies are ranked and sales levels are provided. The regulatory situation is evaluated. On an overall basis, sales for diagnostic products are forecasted to 1985, by hospital clinical labs versus commercial clinical lab applications.

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Professional Liability

The following memorandum from James S. Todd, M.D., in his capacity as Chairman of the Ad Hoc Committee on Professional Liability, was mailed to the membership during the week of May 24th and is here recorded.

It seemed worthwhile to bring the membership up to date on Professional Liability once more prior to the Annual Meeting. This year, information regarding insurance rates will be in your hands well in advance of the meeting. After reading this report, it is imperative that you make your reactions known to your delegates so they may amply represent you at the Convention. Now, as never before, the Society has the opportunity to take a meaningful step toward demonstrating a unified front toward our problems.

Legislatively, good progress is being made. Senator Raymond Garramone (D-Bergen) has introduced seven bills and thus far they have met with no opposition. In addition to our Society's proposals on statute of limitation, *res ipsa loquitur*, informed consent, and collateral source information, the Senator has added two of his own. One would require physicians to report gross incompetence and negligence to the State Board of Medical Examiners and grant immunity from suit for so doing. The other is an act establishing rights of patients when dealing with physicians. This bill codifies what should be standard doctor-patient relationships, and will help avoid suits that now arise from simple misunderstandings. These are Senate Bills 1240-1246 and deserve the active support of you and your patients. It must be reiterated, however, that legislation is only one area of need if rates, and indeed malpractice, are to be controlled.

For the past two months, and Ad Hoc Committee on Professional Liability, the Committee on Medical Defense and Insurance, and the Board of Trustees have been restructuring and negotiating the liability rates for this year. Chubb and Son and the Britton Agency have been candid and helpful without reservation.

The results may be seen in these areas:

1. Umbrella Liability Insurance will continue to

be written by Crum and Forster over a \$1,000,-000/\$3,000,000 base at no additional premium.

2. Radical alterations to the surcharge program have been filed for approval with the New Jersey Insurance Commissioner in keeping with its intended purpose of pin-pointing those with less than acceptable loss experience. Specifically, the proposed surcharge no longer would be a percentage figure of premium, but rather a fixed amount per claim. The surcharge is to apply only to deviations from accepted practice, and only those claims exceeding \$5,000 for non-surgeons or \$10,000 for surgeons will be counted in surcharging.

3. The number of suits filed and, unfortunately, those resulting from indefensible actions by physicians continue to increase. Based on trend alone, the insurance rates ought to increase by 109 per cent. Through a lot of optimism and hard bargaining, and a credit for investment income, Chubb has agreed to write professional liability for an overall 66 per cent increase. While the figure is not low, nevertheless, it is far lower than any comparable state, and one with which we can live, if the Society is willing to recognize the need for cooperative action.

In order to assimilate this rate, some minor alterations in the class structure have been made in consonance with experience, and also some increased emphasis on experience trends within the classes.

The following figures assume a \$750,000/\$2,250,000 policy. (Add 8 per cent for \$1,000,-000/\$3,000,000 and subtract 34 per cent for \$100,000/\$300,000.)

<i>Class</i>	<i>November 1975 Premium</i>	<i>November 1976 Actual Proposed Premium</i>
1	\$ 1,473	\$ 2,878
2	1,849	2,878
3	3,159	5,532
4	6,218	10,838
5-O	11,463	13,492
5-N	17,708	16,143
6	909	1,554
7	579	889
0	787	1,287

These premiums put the emphasis where it belongs and ask no one to support unjustified rates. The saving to the neurosurgeons represent 1/400 of the total premiums, and is inconsequential to everyone except the neurosurgeons. In all classes, experience of losses has been the foundation for determining the final figure.

It is hoped that these rates will be accepted by the Insurance Commissioner and the Society as a contemporary-cooperative compromise which will allow us to get on toward the ultimate solution in the coming year.

Therapeutic Drug Information Center*

The Brookdale Inter-Regional Pharmaceutic and Therapeutic Drug Information Center of the Brooklyn College of Pharmacy, Long Island University, compiles the information contained in this column each month. The Center serves as a source of intelligence on therapeutic and pharmaceutical information not readily available to physicians, at no charge to them, and provides this information with minimal time involvement. It is staffed by trained pharmacists; Jack M. Rosenberg, Pharm. D., Associated Professor and Chairman, Division of Clinical Pharmacy, Brooklyn College of Pharmacy, is Director and Walter Modell, M.D., Emeritus Professor of Pharmacology at Cornell University Medical College, is pharmacologist consultant. The service is available Monday through Friday from 9 a.m. to 4:30 p.m. — telephone (212) 622-8989 or 636-7535. The following are questions and answers handled by the Center recently.

1. Please provide information concerning thioridazine as related to sexual dysfunction in males.

Several case reports describe the absence of ejaculation, orgasm, and erection during coitus or masturbation in males receiving thioridazine (Mellaril) for the treatment of various neurotic or psychotic disorders.¹⁻⁸ However, in most of the cases, the ability of the patients to have erection and orgasm remained intact, but not ejaculation. Singh⁴ reported successful use of thioridazine in the treatment of premature ejaculation. A few patients had reductions in nocturnal emissions,^{2,3} and an occasional patient who reported failure to ejaculate experienced the occurrence of "white urine."

Recently Kotin, *et al.*⁸ reviewed cases of 87 sexually active males — 23 (Group A) were receiving thioridazine alone, 30 (Group B) had taken other major tranquilizers, and the remaining 34 (Group C) had taken both thioridazine and other major tranquilizers at different times and have been included in the data analysis of group A and B. In the thioridazine group (A and C), sexual dysfunction occurred in 60 percent of the patients (44 percent had trouble achieving erection, 35 percent had difficulty maintaining erection, 49 percent reported changes in ejaculation, four patients had changes in the quality of orgasm and two had pain during orgasm). In the other tranquilizer group (B and C), 25 percent had sexual dysfunction (19 percent had difficulty achieving erection, 11 percent had difficulty maintaining erection, two had changes in the quality of orgasm and none reported changes in ejaculation or pain during orgasm). Of the 34 patients (Group C), five reported difficulties in sexual functioning associated with both thioridazine and other major tranquilizers, twenty reported sexual difficulties associated with thioridazine but not with other tranquilizers, and two patients reported difficulties with other major tranquilizers but not with thioridazine. Seven patients had no sexual difficulties.

In most of the case reports and in the above study, the common sexual problems associated with thioridazine are ejaculatory dysfunction. Failure to ejaculate has been reported to occur as early as four hours after a single 50 mg dose of thioridazine,⁸ and appears not to be dose related.² These problems have been reversible soon after discontinuation of thioridazine.^{2,7}

A proposed mechanism for ejaculatory failure is due to alpha adrenergic blockade resulting in retrograde ejaculation^{2,8} or absence of contraction of the seminal vesicle, ampulla, and ductus deferens.⁹ Shader² suggested that although other phenothiazines may show more alpha adrenergic blocking side effects than thioridazine (nasal congestion, postural hypotension, miosis, and gastrointestinal disturbances), the latter may also exert an additional action at peripheral alpha adrenergic sites in the sexual apparatus.

In conclusion, current information suggests that sexual dysfunction associated with thioridazine may be more widespread than previously believed. Although more data are needed to determine the true incidence of this problem, sexual dysfunction occurring in male patients treated with thioridazine must not be considered uncommon.

References

- ¹Taubel DE: Mellaril®: Ejaculation disorders. *Am J Psychiat* 119:87, 1962.
- ²Shader RI: Sexual dysfunction associated with thioridazine hydrochloride. *JAMA* 188:1007-1009, 1964.
- ³Clein L: Thioridazine and ejaculation. *Br Med J* 2:548-549, 1962.
- ⁴Singh, H.: Therapeutic use of thioridazine in premature ejaculation. *Am J Psychiat* 119:891, 1963.

*This month's column was prepared by J. M. Rosenberg, Pharm D., W. A. Simon, Pharm. D., P. Sangkachand, B.S., H. Kirschenbaum, B.S., and M. K. Raina, M. Pharm., Ph.D., Brooklyn College of Pharmacy, LIU.

⁵Freyhan FA: Loss of ejaculation during Mellaril® treatment. *Am J Psychiat* 118:171-172, 1961.

⁶Singh H: A case of inhibition of ejaculation as a side effect of Mellaril.® *Am J Psychiat* 117:1041-1042, 1961.

⁷Greenberg HR and Carrillo C: Thioridazine-induced inhibition of masturbatory ejaculation in an adolescent. *Am J Psychiat* 124:991-993, 1968.

⁸Kotin J, et al: Thioridazine and sexual dysfunction. *Am J Psychiat* 133:82-85, 1976

⁹Kedia K and Markland C: The effect of pharmacological agents on ejaculation. *J Urol* 114:569-572, 1975.

2. I note that Valium® and Librium® are recommended to be initiated at a lower dosage in the elderly. At what age should these reduced dosages be utilized?

It is not uncommon to find increased sensitivity in the elderly to certain therapeutic agents, including the benzodiazepines; e.g. (chlordiazepoxide-Librium®, diazepam-Valium®, flurazepam-Dalmane®, and oxazepam-Serax®). In the case of benzodiazepines, the increased sensitivity is manifested by greater frequency of ataxia, dizziness, oversedation, and confusion. This is the basis for the lower dosage recommendations in the elderly.

Flurazepam has been associated with at least 30 reports of confusion, mainly in elderly and debilitated patients.¹ The Boston Collaborative Surveillance Program reported that the frequency of central nervous system side effects related to chronic diazepam administration has been noted to increase significantly between the age of 40 and 70.²

Klotz, et al.³ conducted an investigation of the effect of age on the deposition and elimination of diazepam. In normal individuals, the plasma half-life of this drug exhibited a striking age dependence; at 20 years of age, the half-life was about 20 hours, but it increased linearly with age to about 90 hours at 80 years, a four to five-fold increase. The authors suggested that the prolongation of the half-life of diazepam with age is primarily dependent on an increase in the initial volume of distribution of the drug. The plasma concentration-time course of the active metabolite of diazepam, desmethyldiazepam, was also affected by age. In older individuals, the initial presence and the peak values of desmethyldiazepam were observed later, and the metabolite was present in lower concentrations. Despite the prolonged half-life with age, the constancy of diazepam clearance indicated that the drug plasma concentration will not accumulate any more in the elderly than the young.

In order to minimize increased central nervous system side effects, particularly in the elderly, the dosage of the benzodiazepines should be initiated at the smallest effective amount and increased gradually as needed and tolerated.⁴ Personal communication with Roche Laboratories indicated that the following initial dosage recommendations appear to be indicated in patients of 60 years of age and older:⁴ flurazepam 15 mg,⁵ chlordiazepoxide 5 mg, two to four times daily,⁶ and diazepam 2 mg to 2½ mg once or twice daily.⁷ In addition the recommended dose of oxazepam in elderly is 10 mg three times daily.⁹

In conclusion, although the mechanism has not been clearly established, geriatric patients appear to be more sensitive to

benzodiazepine derivatives than younger adults. Chronological age is arbitrary and does not necessarily correspond to biological age. However, it appears that in patients 60 years of age and older, the lower dosage recommendation provided in the package inserts for elderly patients should be followed to minimize ataxia, oversedation, dizziness, and confusion.

References

¹Personal correspondence from Anthony Correia, Medical Communications Associate, Professional Services, Roche Laboratories, Oct 20, 1975.

²Boston Collaborative Surveillance Program. 1973: Clinical depression of the central nervous system due to diazepam and chlordiazepoxide in relation to cigarette smoking and age. *N Engl J Med* 288:277-280, 1973.

³Klotz U, et al: The effects of age and liver disease on the disposition and elimination of diazepam in adult man. *J Clin Invest* 55:347-359, 1975.

⁴Personal communication between Roche Laboratories and the author.

⁵Anon: *Physicians' Desk Reference*, Oradell, New Jersey, Medical Economics Company, 1976, p. 1280.

⁶Ibid: p. 1290-1292.

⁷Ibid: p. 1307-1308.

⁸Ibid: p. 1700-1701

3. What is the latest recommended treatment for syphilis?

The incidence of syphilis is increasing sharply, thus it is important to be aware of the latest recommended therapy for this condition.

The drug regimen of choice for patients with early syphilis (primary, secondary, latent syphilis of less than one year's duration) is benzathine penicillin G (Bicillin®, Permapen®) 2.4 million units total by intramuscular injection at a single session, or aqueous procaine penicillin G (Crysticillin®, Duracillin®, Wycillin®) 600,000 units by intramuscular injection daily for eight days. Patients allergic to penicillin should receive either tetracycline hydrochloride or erythromycin (stearate, ethylsuccinate or base) 500 mg four times a day by mouth for 15 days.

Patients with syphilis of more than one year's duration (latent syphilis of indeterminate or more than one year's duration, cardiovascular, late benign, neurosyphilis) should receive benzathine penicillin G 2.4 million units by intramuscular injection weekly for three consecutive weeks, or aqueous procaine penicillin G 600,000 units by intramuscular injection daily for 15 days. Cerebrospinal fluid (CSF) examination is mandatory in patients with suspected symptomatic neurosyphilis. It should also be noted that some clinicians prefer to hospitalize patients with neurosyphilis, particularly if they are symptomatic or have not responded to initial therapy. In these instances, patients are treated with 12 to 24 million units of aqueous crystalline penicillin each day for ten days. Patients allergic to penicillin should be treated with either tetracycline hydrochloride or erythromycin (stearate, ethylsuccinate or base) 500 mg four times a day by mouth for 30 days.

Patients at all stages of pregnancy, who are not allergic to penicillin, should receive penicillin in dosage schedules appropriate for the stage of syphilis as recommended for the treatment of nonpregnant patients, while pregnant patients allergic to penicillin should receive erythromycin (stearate, ethylsuccinate or base) in dosage schedules appropriate for the stage of syphilis as recommended for the treatment of nonpregnant patients.

Infants suffering from congenital syphilis, and having an abnormal CSF should receive aqueous crystalline penicillin G, 50,000 units/kg intramuscularly or intravenously daily in two divided doses for a minimum of ten days, or aqueous procaine penicillin G, 50,000 units/kg intramuscularly daily for a minimum of ten days. Infants with normal CSF should receive benzathine penicillin G, 50,000 units/kg intramuscularly in a single dose. (Although benzathine penicillin has been previously recommended and widely used, published clinical data on its efficacy in congenital neurosyphilis are lacking. If neurosyphilis cannot be excluded, the procaine or aqueous penicillin regimen are recommended.)

Physicians are cautioned to use *no less* than the recommended dosages of antibiotics.

Reference

¹Anon: Syphilis — CDC recommended treatment schedules. *Morbidity and Mortality Weekly Report*, HEW, 25:101-107, 1976.

PHYSICIANS SEEKING LOCATION IN NEW JERSEY

The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

ANESTHESIOLOGY — J. W. Chen, M.D., 25 Springfield Avenue, Hasbrouck Heights 07604. Taipei (Taiwan) 1970. Board eligible. Group, partnership, solo, or hospital. Available July 1976.

Sumedha V. Kulkarni, M.D., 318 East 15th Street, New York 10003. Poona (India) 1964. Board eligible. Group, partnership, or hospital. Available July 1976.

CARDIOLOGY — Samuel P. Kumar, M.D., 4729 Hickory Place, Cheyenne, Wyoming 82001. Osmania Medical College (India). Subspecialty, internal medicine. Board certified. Group. Available July 1976.

FAMILY PRACTICE — Shiv N. Radtogi, M.D., 1641 Third Avenue, Apt. 12-E, New York 10028. S.N. Medical College, Agra (India). Also general surgery. Group, partnership, or solo. Available July 1, 1976.

INTERNAL MEDICINE — Stephen R. Shapiro, M.D., 3151 Lake Forest Drive, Apt. 69, Augusta, Georgia 30904. Chicago Medical School 1969. Subspecialty, gastroenterology. Board eligible. Group, partnership, or solo. Available July 1976.

Hari K. R. Bhasin, M.D., 1145½ Hartford Avenue, Apt. 1C, Johnston, Rhode Island 02919. All-India Institute of Medical Sciences, 1966. Subspecialty, nephrology. Board eligible. Hospital, group, or solo. Available July 1976.

Nancy S. Scher, M.D., 142 East 16th Street, Apt. 6-A, New York 10003. Pennsylvania 1971. Board certified (IM). Subspecialty, hematology. Group, preferably southern New Jersey. Available July 1976.

Sinlaratana Pairojana, M.D., 300 Community Drive, Apt. 4-1B, Manhasset, Long Island, New York 11030. Siriraj, Bangkok (Thailand) 1966. Board certified. Subspecialty, hematology. Group or partnership (hospital based). Available July 1976.

Ashok Kumar, M.D., 345 Bronx River Road, Apt. 7-C, Yonkers, New York 10704. SMS Medical (Jaipur, India) 1967. Board certified. Group, partnership, or solo. Available July 1976.

OBSTETRICS AND GYNECOLOGY — Stanley Wilson Yang, M.D., 675 East 233rd Street, Bronx, New York 10466. Rangoon University Medical School (Burma) 1969. Board eligible. Group, partnership, solo. Available July 1976.

Wu-Jan Lin, M.D., 67-50 Thornton Place, Apt. 1K, Forest Hills, New York 11375. Taipei (Taiwan) 1970. Board eligible. Solo, partnership, group. Available July 1976.

Narendra D. Karmali, M.D., 753 Classon Avenue, Apt. 2-D, Brooklyn, New York 11238. T. N. Medical (Bombay, India) 1970. Board eligible. Group, partnership. Available July 1976.

PATHOLOGY — Thomas J. Joseph, M.D., 46 Brighton Drive, Gaithersburg, Maryland 20760. Temple 1970. Board certified. Group or partnership. Available May 1977.

PEDIATRICS — Jaw-Tang Chen, M.D., 3990 Bronx Boulevard, Apt. LK, Bronx, New York 10466. Taipei (Taiwan) 1967. Board eligible. Solo, partnership, or group. Available.

Michael Z. Blumberg, M.D., 701 North Lincoln Street, O'Fallon, Illinois 62269. Jefferson 1971. Subspecialty, allergy. Board certified. Group or partnership. Available July 1977.

David Spiller, M.D., 401 East 86th Street, Apt. 11-K, New York 10028. New York Medical College 1972. Board eligible. Solo. Available July 1976.

SURGERY — Vijaykumar Kulkarni, M.D., 318 East 15th Street, New York 10003. Poona (India) 1965. Board eligible. Group, partnership, or solo. Available July 1976.

UROLOGY — Edward Salmon, M.D. 4343 Graham Drive, Pierrefonds, Quebec H9H2B9, Canada. University of Kentucky, 1969. Board eligible. Group, partnership, or solo. Available July 1976.

LETTER TO THE JOURNAL

No Smoking!

Dear Sir:

May 11, 1976

Some time ago (March 1975) an editorial appeared in your *Journal* entitled "Smoking: Is Our House in Order?" questioning the permissiveness of many physicians toward smoking in health facilities and in their own offices and waiting rooms. You are to be commended for this enlightened statement. Nevertheless, it seems to me that many physicians, including those who would not smoke themselves, have not heard your message.

The overpowering evidence of the harm being caused by smoking recently was highlighted by the seminar at Cherry Hill titled "New Jersey Leads the Nation in Cancer Deaths — Why?" I am afraid that the majority of physicians in this state are missing one opportunity to make a contribution to the eradication of lung cancer and to general health education.

The posting of a single sign (No Smoking!) and the removal of *all* ash trays from the waiting room has been proved to be 100 percent successful in eliminating smoking in one doctor's office. Why? Because of his authority, his image, and his position as the healer. Take courage, doctor, don't apologize, just put up the sign, put the ash trays out of the building, and reap the respect if not admiration of your patients!

(signed) Thomas B. Gilbert
State Coordinator
Cancer Control Services

ANNOUNCEMENTS

Glaucoma Congress

A joint meeting of the American Society of Contemporary Ophthalmology and the International Glaucoma Congress will be held at the Diplomat Hotel in Hollywood, Florida from January 30 to February 5, 1977. The Glaucoma Congress convenes on January 31 and February 1 and the programs for the remainder of the week cover cataract, cornea, retina, and oculoplastic surgery and pediatric ophthalmology. The AMA Physician's Recognition Award will grant 42 credit hours in Category I for attendance. For information, please write to Dr. John Bellows, 30 N. Michigan Avenue, Chicago 60602.

Graduate Courses Held in Florida

The Annual Scientific Assembly of the American Society of Contemporary Medicine and Surgery will be held at the Diplomat Hotel in Hollywood, Florida from January 30 to February 5, 1977. The programs include

seminars on cardiovascular disease, hypertension, cancer, infectious diseases, cryosurgery, nutrition/alimentation, special surgery, genitourinary disease, pulmonary disease, and others. The program has been approved for up to 40 credit-hours in Category I of the AMA Physician's Recognition Award. For information, please write to John Bellows, M.D., 30 North Michigan Avenue, Chicago 60602.

Alcoholics Anonymous Convention

International Doctors in Alcoholics Anonymous is a non-dues-paying organization of physicians and dentists who get together at least yearly to help each other obtain and maintain their sobriety and freedom from alcohol or other drugs. The next annual convention will be held August 5 through 8 at the Los Angeles Marriott Hotel. Expenses are tax-deductible and newcomers are welcome. Inquiries should be directed to: Secretary, IDAA, 1950 Volney Road, Youngstown, Ohio 44511.

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phone mornings (212) 245-4737.

MEETINGS OF MEDICAL INTEREST

This listing is compiled through the cooperation of the Committee on Medical Education of The Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the College of Medicine and Dentistry of New Jersey. For information on accreditation, please contact the sponsoring organization(s).

July

- 1 Pulmonary Embolism, Part I
- 8 Pulmonary Embolism, Part II
- 15 Electrocardiogram of the Middle-Aged
- 22 The Modern Medical School and Patient Care
- 29 Child Abuse
12 noon — Carrier Clinic, Belle Mead
(Sponsored by Carrier Clinic)
- 23 Seminar in Transactional Analysis and Gestalt Therapy
- 24 9 a.m.-5:30 p.m. — Ramada Inn, Fairfield
- 25 (Sponsored by Kenneth Hall, M.D., and Academy of Medicine)
- 27 Thyroid Today
8-9 p.m. — Warren Hospital, Phillipsburg
(Sponsored by Warren Hospital and Academy of Medicine)

Aug.

- 3 Lecture Series
11 a.m. — Overlook Hospital, Summit
(Sponsored by Overlook Hospital and AAFP)
- 5 Therapy of Sexual Disorders
12 noon — Carrier Clinic, Belle Mead
(Sponsored by Carrier Clinic)
- 12 Marital Therapy
12 noon — Carrier Clinic, Belle Mead
(Sponsored by Carrier Clinic)
- 25 Emergency Medical Procedures
- 26 Martland Medical Center, Newark
- 27 (Sponsored by CMDNJ — New Jersey Medical School)

Sept.

- 9 Neurological Causes for Violent Behavior
12 noon — Carrier Clinic, Belle Mead
(Sponsored by Carrier Clinic)
- 10 Indications for Gastroenterological Endoscopy
12 noon-1 p.m. — St. Mary's Hospital, Orange
(Sponsored by St. Mary's Hospital and Academy of Medicine)
- 15 Continuing Education Program
- 29 Passaic General Hospital, Passaic
(Sponsored by Hahnemann Medical College and Hospital and AAFP)
- 16 Second Memorial Ignatz Semmelweis Seminar
- 19 12 noon (9/16) — Cherry Hill Inn, Cherry Hill
(Sponsored by CMDNJ-New Jersey Medical School, Academy of Medicine, and AAFP)

17 Human and Animal Obesity

11 a.m.-12 noon — Ciba-Geigy, Inc., Summit
(Sponsored by Ciba-Geigy, Inc., and Academy of Medicine)

21 Anesthetic Management of Drug Abuse Patient

8-9 p.m. — Ramada Inn, Clark
(Sponsored by New Jersey State Society of Anesthesiologists and Academy of Medicine)

21 Transfusion Therapy

5:30-6:30 p.m. — St. Mary's Hospital, Orange
(Sponsored by St. Mary's Hospital and Academy of Medicine)

22 Advances in Internal Medicine and Therapeutics

9-11 a.m. — Middlesex General Hospital, New Brunswick
(Sponsored by Middlesex General Hospital and Academy of Medicine)

29 Depression

1-3 p.m. — Ancora Psychiatric Hospital, Hammonton
(Sponsored by Ancora Psychiatric Hospital and Academy of Medicine)

29 Pitfalls in Emergency Medical Care

9 a.m.-5 p.m. — Holiday Inn of New Brunswick North Brunswick
(Sponsored by Inter-Agency Commission on Emergency Medical Care and Academy of Medicine)

Oct.

1-3 9th Annual Cardiovascular Care Conference

Haddon Hall, Atlantic City
(Sponsored by American Heart Association, New Jersey Affiliate, and Academy of Medicine)

13 Post-Partum Psychosis and Depression

7:45-10 p.m. — 111 Ridgewood Avenue, Glen Ridge
(Sponsored by Journal Club of Greater Newark and Academy of Medicine)

13 Continuing Education Program

27 Passaic General Hospital, Passaic
(Sponsored by Hahnemann Medical College and Hospital and AAFP)

26 Oncology and Hematology

8-9 p.m. — Warren Hospital, Phillipsburg
(Sponsored by Warren Hospital and Academy of Medicine)

Nov.

10 Annual Fall Meeting

9 a.m.-6 p.m. — Robert Treat Hotel, Newark
(Sponsored by Academy of Ophthalmology and Otolaryngology and Academy of Medicine)

- 10 **Continuing Education Program**
Passaic General Hospital, Passaic
(Sponsored by Hahnemann Medical College and Hospital and AAFP)
- 23 **Cardiac Complications of Antidepressants and Tranquilizers**
8-9 p.m. — Warren Hospital, Phillipsburg
(Sponsored by Warren Hospital and Academy of Medicine)

Dec.

- 3 **Melanoma and Recent Immunologic Advances**
12 noon-1 p.m. — St. Mary's Hospital, Orange
(Sponsored by St. Mary's Hospital and Academy of Medicine)
- 8 **Continuing Education Program**
22 Passaic General Hospital, Passaic
(Sponsored by Hahnemann Medical College and Hospital and Academy of Medicine)

OBITUARIES

Dr. George A. Bradasch

On May 13, 1976, George A. Bradasch, M.D., a member of our Hudson County component, died in St. Francis Hospital, Miami Beach, Florida where he was living in retirement. Born in 1908 and graduated from Long Island College of Medicine in 1935, Dr. Bradasch had offices in Union City most of his professional life. Initially he specialized in anesthesiology and was director of that department at St. Mary's Hospital in Hoboken during the 1950s. Later he pursued a career in surgery and was an associate in that department at the same hospital. Dr. Bradasch was a Fellow of the American College of Anesthesiology and of the International College of Surgeons.

Dr. John R. Burbridge

One of Mercer County's senior members, John R. Burbridge, M.D., a well-known Princeton internist, died on May 1 in Massachusetts General Hospital in Boston. A graduate of George Washington University Medical School in 1931, Dr. Burbridge served his residency in Union Memorial Hospital in Baltimore. He came to New Jersey in 1939 and joined the staff at Princeton Hospital where he had had various appointments including chairman of the department of medicine and chief of the section on internal medicine. Dr. Burbridge was a member of the American Academy of Chest Physicians, the American Geriatric Society, and the New Jersey Diabetes Association. He had been one of the physicians associated with Princeton Univer-

sity's McCosh Infirmary. He was a member of the Princeton Borough Board of Health and for three years its president. He was medical inspector for the borough's schools and currently was medical advisor to the Educational Testing Service. He had been an instructor of medicine at the University of Pennsylvania School of Medicine. During World War II Dr. Burbridge was a flight surgeon with the United States Air Force. He was 75 years old at the time of his death.

Dr. Francis P. Colizzo, Jr.

At the untimely age of 40, Francis P. Colizzo, Jr., M.D., a member of the Sussex County Medical Society, died on May 6. A graduate of Hahnemann Medical College, Class of 1962, Dr. Colizzo pursued a residency in surgery at Mercy Catholic Medical Center in Philadelphia and became board certified in that field. He was a Fellow of the American College of Surgeons and a member of the Academy of Medicine in New Jersey. Dr. Colizzo had staff appointments in the department of surgery at Newtown Memorial Hospital where he was chief of that section, at Franklin Hospital in Franklin, and Community Hospital in Hackettstown.

Dr. Herman C. Comora

A senior member of our Bergen County component, and formerly a member of the Hudson County Medical Society, Herman C. Comora, M.D., died on May 19. Born in Warsaw, Poland, Dr. Comora emigrated to the United States and was graduated from Bellevue Medical School in New York in 1919. He took graduate work in otolaryngology and later in plastic surgery at New York Postgraduate Hospital, and was board certified in the former.

Dr. Comora had offices in West New York and in New York City and was associated with North Hudson Hospital in Weehawken, with Hasbrouck Heights Hospital, Christ Hospital in Jersey City, and Presbyterian Medical Center in New York. He was 82 years old at the time of his death.

Dr. John J. Connolly

We have learned of the death of John J. Connolly, M.D. on April 7 at his home following a prolonged illness. A member of our Essex County Medical Society, Dr. Connolly practiced general surgery in Newark for many years, retiring to Spring Lake in 1970. He was graduated from New York University College of Medicine in 1924 and pursued graduate work in surgery and anatomy. He had been on the surgical staff at Presbyterian, Crippled Children's and St. Michael's Hospitals in Newark, (where at the latter he was director of the department) and at St. Mary's Hospital in Orange. Dr. Connolly was a Fellow of the American College of Surgeons and a member of the Academy of Medicine of New Jersey. He was 77 years old at the time of his death.

Dr. George Ginsberg

At the grand age of 84, George Ginsberg, M.D., a member of the Hudson County component, died on May 7 at St. Mary's Hospital, Hoboken. Dr. Ginsberg received his medical degree from New York University School of Medicine in 1914 and practiced internal medicine, with special emphasis on cardiology, in the Hoboken area most of his professional life. He was a Fellow of the American College of Physicians, a member of the American Diabetes Association, and had been on the staff at St. Michael's Hospital in Newark, North Hudson Hospital in Weehawken, and St. Mary's Hospital in Hoboken, where he was president of the staff during the 1950's.

Dr. Albert S. Harden, Jr.

One of Essex County's senior members, Albert S. Harden, Jr., M.D., died on May 9. Born in 1907 and a graduate of the University of Penn-

sylvania School of Medicine, class of 1932, Dr. Harden pursued graduate work in pediatrics and practiced that specialty first in Newark and then in Maplewood until his retirement to New Hampshire in 1968. He was certified by the American Board of Pediatrics and was a Fellow of the American Academy of Pediatrics. His hospital appointments had included Presbyterian and Babies' Hospitals in Newark and Orange Memorial Hospital. Dr. Harden was active in community affairs and had been police surgeon and health commissioner in his home community and a member of the Essex County Park Commission.

Dr. W. James Marquis

On May 9, W. James Marquis, M.D. a member of the Essex County component died at his home. A graduate of Harvard Medical School in 1922, Dr. Marquis went on to take graduate work in radiology. He was board certified in that field and was a Fellow of the American College of Radiology and a member of the American Roentgen Ray Society and the Radiological Society of North America. He had had offices in East Orange and was affiliated with the East Orange General Hospital and in Newark with Presbyterian and Babies' Hospitals. Dr. Marquis had retired to Summit in 1969. He was 80 years old at the time of his death.

Dr. Camille Mermod

Camille Mermod, M.D., a member of our Essex County component, died at her home on April 28th after a prolonged illness. Born in Switzerland, Dr. Mermod was graduated from Stanford Medical School in 1932 and practiced in California and Pennsylvania before coming to New Jersey in 1950. She worked as a pathologist for Hoffmann-La Roche in Nutley before establishing a private practice in Orange. Dr. Mermod was board certified in clinical pathology and pathologic anatomy. She had been on the attending staff at St. Barnabas Medical Center in Livingston, and was affiliated with Memorial Hospital in Orange and East Orange General. In 1959 Dr. Mermod had been chosen New Jersey's Medical Woman of the Year and in the early 1960s had served a term as president of the American Medical Women's Association.

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Published monthly (since 1904), under direction of the Committee on Publication, by The Medical Society of New Jersey, 315 West State St., Trenton, N.J. Printed in Hanover, New Hampshire by the Dartmouth Printing Co. Whole number of issues 864. Member's subscription (\$5) is included in Society dues. Rates for nonmembers, \$10; outside USA add \$2.50 for postage. Single copies, \$1. Address communications to *The Journal*, MSNJ, P.O. Box 904, Trenton, N.J. 08605 (609) 394-3154. Second class postage paid at Trenton, N.J. and additional entry office. Copyright 1976 by The Medical Society of New Jersey.

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These usually subside in several hours but supportive and symptomatic therapy, including hospitalization, may be necessary.

Pregnancy and Lactation: Safe use not established; weigh potential benefits against potential hazards in pregnancy, nursing mothers (concentrations in breast milk are two to four times that in plasma), or women of childbearing potential.

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Potentially Hazardous Tasks: Driving a motor vehicle or operating machinery.

Additive Effects: Effects of carisoprodol and alcohol, other CNS depressants or psychotropic drugs may be additive.

Drug Dependence: Use cautiously in addiction-prone patients.

Precautions: To avoid excess accumulation, use caution in patients with compromised liver or kidney function.

Adverse Reactions: *Central Nervous System:* Drowsiness, dizziness, vertigo, ataxia, tremor, agitation, irritability, headache, depressive reactions, syncope, insomnia, idiosyncrotic reaction (see "Warnings").

Allergic or Idiosyncrotic: In previously unexposed patients, these are usually seen after 1-4 doses and include rash, erythema multiforme, pruritus, eosinophilia, fixed drug eruption with cross reaction to meprobamate. Asthmatic episodes, fever, weakness, dizziness, angioneurotic edema, swelling eyes, hypotension and anaphylactoid shock may be manifestations of severe reactions.

In such cases, stop carisoprodol and initiate appropriate treatment (e.g., epinephrine, antihistamines, corticosteroids).

Cardiovascular: Tachycardia, postural hypotension, facial flushing.

Gastrointestinal: Nausea, vomiting, hiccup, epigastric distress.

Hematologic: Leukopenia and pancytopenia (on carisoprodol plus other drugs).

Usual Adult Dosage: One 350 mg tablet three times daily and at bedtime.

Overdosage: Has produced stupor, coma, shock, respiratory depression, and, very rarely, death. The effects of an overdosage of carisoprodol and alcohol or other CNS depressants or psychotropic agents can be additive even when one of the drugs has been taken in the usual recommended dosage. Empty stomach, treat symptomatically; cautiously give respiratory assistance, CNS stimulants, pressor agents as needed. Carisoprodol is metabolized in the liver and excreted by the kidney. Diuresis and dialysis have been used successfully with related drug meprobamate. Carefully monitor urinary output; avoid overhydration; observe for possible relapse due to incomplete gastric emptying and delayed absorption.

Before prescribing, consult package circular or latest PDR information.

1. Hindle, T.H. III: Calif. Med. 117:7 (Aug.) 1972. 2,3. Unpublished Data on file, Medical Department, Wallace Laboratories, Cranbury, N.J.

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EDITORIALS

Decision '76.

Like most medical societies, The Medical Society of New Jersey continues to wrestle with the problems of professional liability. Unlike most, our organization does not face the catastrophe of no insurance or rates beyond the ability of the physician to pay. Since the December, 1975 meeting of the House of Delegates, the Ad Hoc Committee on Professional Liability has worked hard to accomplish the mandates of that House, while attempting to maintain cohesive support within the Society.

The record to date is not altogether discouraging. Nine of the seventeen items approved by the House have either been implemented or are in the process of effectualization. Our legislative package has been introduced into the State Senate and, at this time, stands an excellent chance of passage. No mistakes have been made in terms of futile legislative or public relations endeavors. Adequate insurance is available.

In order to ameliorate the unfavorable rate structure, your representatives reviewed all current figures with the insurance carriers and agreed that a 66 percent rate increase is justified by the experience to date. Apportionment of this figure was not easy since some physicians would be paying in excess of \$30,000 in basic premiums alone, under our current concepts.

It was quite clear that standard allocation of premiums was no longer defensible, and that no sector of the Medical Society was willing directly to subsidize other groups. Consequently, new emphasis was placed on developing trends in the various categories in relation to claims assertion and presumed future losses. By so doing, a 95 percent increase for Class I could be justified. By the same approach, Classes 2, 5, 7 and 0 were rated below the 66 percent average. The net result was an allocation of premium based on actual losses and anticipated activity without the imposition of arbitrary figures.

One of the most significant decisions of the 1976 House of Delegates was to ratify the rate proposals as recommended by the Board of Trustees. In so doing, MSNJ has demonstrated a new and vital sense of restraint and cooperation among its members. Furthermore this decision will stimulate the important programs (designed to solve the liability crisis) to move forward.

If society expects to be compensated for all the untoward events of medical care — and all evidence suggests that it does — then the final solution to the medical liability problem cannot be professional but must be societal. Thus far, no measure proposed anywhere attempts to do anything more than reduce cost without addressing the basic issue.

The action of the House of Delegates exposes an exciting spirit of mutualism which will allow the Society to approach meaningful goals such as the innovative concepts and proposals which are already under study.

It may well be that the crucial decision made in '76 will be the forerunner of a solution for '77.
James S. Todd, M.D.

AMA and PL 93-641

The American Medical Association is so convinced that the new health planning law (PL 93-641) is unconstitutional that our representatives have requested permission to join with the State of North Carolina in a legal suit in federal court to determine the constitutionality of the act. This so-called "Health Planning Act of 1974" is considered "the framework for a bureaucratic totalitarianism that could reshape the health care system as we know it."

While all agree that health planning is essential and that costly overconstruction of hospitals is unreasonable, the health planning act has the propensity to develop a regulatory morass into which the best features of American medical care may sink — never to be retrieved.

Consider the following:

- The Secretary of HEW is to dominate five somewhat overlapping levels of federal, state, and local authority. He is also to issue national health planning policy, appoint a national advisory council, approve state and local planning agencies and the funds they receive, and establish the criteria and procedures they use.

- Certificate-of-need legislation must be adopted in all states, as prescribed by the HEW Secretary. The need for all new institutional facilities and services must be certified; the need for all existent institutional services must be reviewed every five years. Practice-profile data from PSROs, plus the minority status of direct providers of care on local planning boards, could arbitrarily influence the expansion or continuation of services.

- Up to six states are to get federal grants to demonstrate rate regulation for health services. This could become mandatory for all states and encompass physicians, if various planners get their way. The result of regulation is likely to be an obsession with cost at the expense of high-quality care.

As with many other examples of social legislation, the end-result will be more regulatory power in the hands of new agencies, a situation which many believe to be "a direct cause of the nation's high rate of inflation." In questioning "Who's Regulating the Regulators?", William Hoffer* placed his finger "on the button:"

"Bureaucrats at the Consumer Product Safety Commission in Washington ordered 80,000 brightly-colored lapel buttons a few Christmases back, to remind parents to purchase safe toys for their children. Before the buttons could be distributed, an obscure inspector realized that they were colored with lead paint and, if licked by children, could cause lead poisoning.

"So the Consumer Product Safety Commission was forced to ban all 80,000 of its own safety buttons.

"Increasingly, it seems, Washington calls upon the nation's taxpayers to pay for such foolishness. The right hand of the country's regulators, commissioners, inspectors, and other assorted agency watchdogs doesn't know what the left hand is doing. As it becomes evermore ponderous and expensive, government also becomes more ineffective."

A.K.

**The Ambassador*, June 1976

Highlights of the 1976 House of Delegates*

The House adopted the following resolutions at the 210th Annual Meeting:

—Emphasize the expulsion and delicensure of those physicians in our midst who would defame the good name of our honored profession.

—Petition Medical-Surgical Plan of New Jersey and the Commissioner of Health to change the contract to allow assignment of benefits.

—Reapprove the \$200 per member assessment to support professional liability actions of MSNJ and make its payment mandatory for all regular dues-paying members; dues-exempt members are not required to make the payment.

—Oppose any legislation that would broaden the scope of optometry under New Jersey law.

—Oppose any legislation which will restrict or interfere with the use of physician assistants in any way that singles out one particular specialty.

—Request the legislature to amend the date of January 1, 1973 as the cut-off point when a minor's suit can be brought for personal injuries.

—Oppose any legislation that would allow the use of drugs of any type for diagnostic or other purposes by non-medical eye practitioners except under the direction of a licensed physician.

—Urge New Jersey Medical and Dental Schools to encourage teaching related to hypnosis.

—Create a new committee to serve the specialty of otolaryngology with conservation of hearing as one of its functions.

—Commend the outstanding service rendered to the annual meetings by Arthur Bernstein, M.D.

—Bring to the attention of the Legislature and the Governor the necessity for early routine education in the schools on the prevention of alcoholism.

*Details can be found on pages Tr 116-133, this issue.

—Offer an advisory committee of knowledgeable physicians to the Department of Education to formulate and implement integrated health and nutrition educational programs for all New Jersey schools.

—Recommend that there be no change in the present involuntary psychiatric commitment laws and oppose legislation which would permit psychologists to sign commitment forms.

—Oppose the use of the Social Security number as a universal identifier.

—Oppose fees for CME programs which are in excess of the reasonable cost of the program.

—Determine that a physician fulfills his obligation to his patients by submitting a standard HIC form.

—Determine that exemptions from CME be limited to poor health, age, or infirmity.

—Actively oppose S-831 and S-1354 of 1976 dealing with physicians' assistants.

—Support an appropriate influenza vaccination program.

—Urge the full weight of governmental, medical, industrial, and public expertise quickly be brought to bear on the problem of cancer in New Jersey.

—Actively oppose S-889 so that all suspected cases of child abuse are to be reported to the Division of Youth and Family Services.

—Study the health implications of an atomic energy plant off the coast of New Jersey. A.K.



Dr. John Cochran—engraving by William Satchwell Leney (1769-1831)

Dr. Cochran was a founder and president of The Medical Society of New Jersey (1768-1770). He was appointed Physician and Surgeon General in the Middle Department of the Army, April 10, 1777, and subsequently became Chief Physician and Surgeon.

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[†]due to susceptible organisms

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- Contraindicated during pregnancy and the nursing period and in infants under 2 months of age.
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Contraindications: Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

Warnings: Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-hemolytic streptococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, epidermal necrosis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *gastrointestinal reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long administration. Cross-sensitivity with these agents may exist.

Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age (except adjunctively with pyriminamine in congenital toxoplasmosis).

Usual adult dosage: 2 Gm (4 tabs or teasp.) initially, then 1 Gm *b.i.d.* or *t.i.d.* depending on severity of infection.

Usual child's dosage: 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, then 0.25 Gm/20 lbs *b.i.d.* Maximum dose should not exceed 75 mg/kg/24 hrs.

Supplied: Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole/teaspoonful.



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DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-4-androst-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and hypogonadism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-pubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged use of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and hypogonadism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpubertal cryptorchidism, 30 mg. **REFERENCE:** Robert B. Greenblatt, M.D., and D. H. Perez, M.D.: "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Vitamin B-12	1.5 mcg

Methionine	12 mg
Choline Bitartrate	15 mg
Inositol	10 mg
Calcium Pantothenate	2.5 mg
Pyridoxine	0.25 mg
Copper (from Copper Sulfate)	0.25 mg
Zinc (from Zinc Oxide)	0.25 mg
Iodine (from Potassium Iodide)	0.075 mg
Calcium (from Dicalcium Phosphate)	72.5 mg
Phosphorus (from Dicalcium Phosphate)	55 mg
Potassium (from Potassium Sulfate)	2.5 mg
Manganese (from Manganese Sulfate)	0.5 mg
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ACTION AND USES DOSAGE: 1 tablet after breakfast and supper or as required. In females, 3-week courses of therapy are recommended followed by a 1-week rest period. Withdrawal bleeding may occur during the rest period. **PRECAUTIONS:** Administer cautiously to female patients who tend to develop excessive hair growth or other signs of masculinization. **CONTRAINDICATIONS:** Patients in whom estrogen or androgen therapy should not be used, as in carcinoma of the breast, genital tract, or prostate, and in patients with a familial tendency to these types of malignancy. **AVAILABLE:** Bottles of 100 and 500 tablets.

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2. The plan is to apply the All Services Index to physicians' increases as an allowable maximum in the UCR program.

3. Blue Shield is to study a plan to effectively cover a greater degree of the charges for more expensive, complex procedures in the UCR program.

4. Blue Shield is to identify the most cost-efficient laboratories to develop a revised laboratory fee schedule which will become the limit of payment to all laboratories. Lists of participating laboratories are to be sent to physicians to encourage use of those facilities to assure no balance billing to patients. The Insurance Department and Blue Shield are to seek the cooperation of Blue Cross to develop a like program designed to limit payment to hospitals under Rider J.

5. Blue Shield, at the request of the Insurance Department, is to launch a public relations and advertising campaign urging subscribers to utilize participating physicians and laboratories so that the Blue Shield payment will be accepted as payment-in-full for subscribers who are under the income limits of the fixed-fee programs or who are covered by the UCR program.



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Provides overlapping, broad-spectrum antibacterial action to help combat infection caused by common susceptible pathogens (including staph and strep).

Each gram contains: Aerosporin[®] brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

INDICATIONS: Therapeutically (as an adjunct to systemic therapy when indicated) for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.

Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing. **CONTRAINDICATIONS:** Not for use in the eyes or external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to



neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended. **PRECAUTIONS:** As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. **ADVERSE REACTIONS:** Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.



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Each blue tablet contains:
Nicotinic Acid 100 mg.
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Thiamine HCL (B-1) ... 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) ... 10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500, 1000.

LIPO-NICIN/250 mg.
Each yellow tablet contains:
Nicotinic Acid 250 mg.
Nicotinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) ... 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) ... 10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500, 1000.

GRADUAL RELEASE

LIPO-NICIN/300 mg.
Each time-release capsule contains:
Nicotinic Acid 300 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) ... 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) ... 10 mg.
In a special base of prolonged therapeutic effect.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient. **Side Effects:** Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur. **Contraindications:** Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.



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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, apprehension, fatigue, depression, or agitation; symptomatic of acute agitation, tremor, delirium states and hallucinosis due to acute withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to neurologic pathology, spasticity caused by motor neuron disorders, athetosis, chorea, or convulsive disorders (as sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 years of age. Acute narrow angle glaucoma. May be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic states. Caution against hazardous activities requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of anticonvulsant medication; withdrawal may be associated with temporary increase in frequency and severity of seizures. Advise against simultaneous ingestion of alcohol in CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, sweating). Keep addicted individuals under careful surveillance because of their predisposition to relapse and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other CNS depressants or anticonvulsants, carefully study pharmacology of agents involved; drugs such as phenothiazines, barbiturates, MAO inhibitors, or other antidepressants may potentiate sedation. Usual precautions indicated in severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and avoid to preclude ataxia or over-sedation.

Side Effects: Drowsiness, confusion, ataxia, hypotension, changes in libido, fatigue, depression, dysarthria, rash, skin rash, ataxia, constipation, incontinence, changes in salivary secretion, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperreflexia, states, anxiety, hallucinations, increased muscle spasticity, insomnia, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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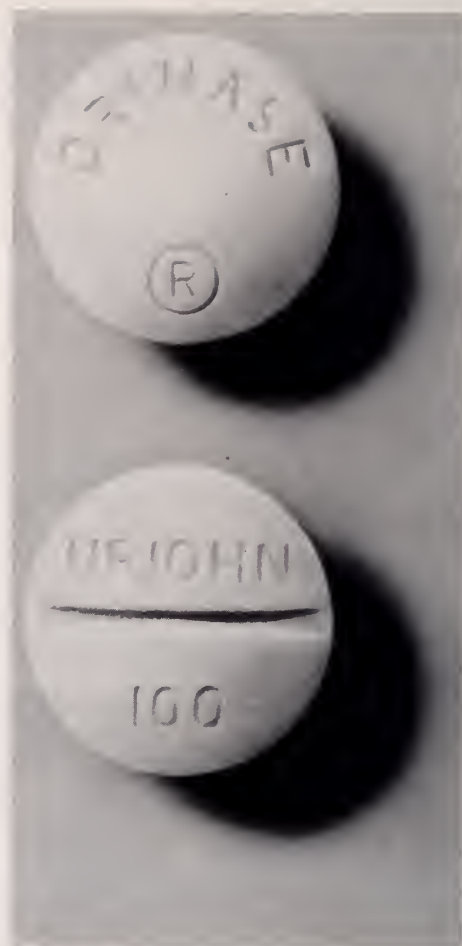
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TRANSACTIONS

1976 House of Delegates

210th ANNUAL MEETING

The Medical Society of New Jersey

June 5-8, 1976

John S. Madara, M.D.
President, MSNJ, 1976-1977



with Mrs. Madara



receiving President's Plaque from Immediate
Past President James A. Rogers, M.D.

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ANNUAL REPORTS

President

John J. McGuire, M.D., South Orange

(Reference Committee "A")

To all of you who, during the past year of my administration, have taken the time to write to me and to give me the benefit of your thinking, I wish to take this opportunity to say, "The same to you, Fellow!"

It was a rough year representing you. Categories such as professional liability and Medicaid, subjects which have languished in an imperfect state for years, suddenly erupted and demanded all of our time. It was a year of change, deadlines, and crises. I should like to bask in a feeling of rewarding accomplishment for all the hard work and many meetings. Yet, some of the problems could not be solved in the allotted twelve months, and I know some of the solutions are but temporary.

MEDICAID

Last August physicians and other health providers received the famous 10 percent slash in Medicaid reimbursement, which actually amounted to more than a 10 percent reduction in an already antiquated fee schedule. All during the Fall we held meetings with Governor Brendan Byrne, with committees from specialty societies, with local medical representatives, and we met directly with members of the Medicaid program. There were no monies to pay the 10 percent differential.

The Governor and Medicaid officials agreed that, if legislators would return the fundings which they had cut from the total Medicaid budget, they would immediately reinstate the cuts to providers. So far, the legislators haven't acted as we would desire in this matter.

PROFESSIONAL LIABILITY

Here is a topic which carries good news, bad news, and many challenges for the future. All national proposals to solve the problem (mainly bills by Senator Kennedy) are unacceptable, and

since liability laws are State oriented, we knew where to focus. One problem was that our Insurance Commissioner James Sheeran came up with a reinsurance bill which was not in the interest of the physician, the insurance carrier, or the public. Yet, despite our and other objections, the bill was passed and signed into law in an atmosphere of stormy protest. I hear that some liability carriers are already pulling out of this State because of this poor legislation.

On the positive side, bills were developed by MSNJ and five of them have been introduced in the Senate, as follows:

Statute of Limitations (two separate bills)	S-1240
	S-1241
Res Ipsa Loquitur	S-1242
Informed Consent	S-1243
Collateral Source Law	S-1244

Another bill, which has to do with arbitration, is still being studied and edited by members of the Attorney General Staff.

All bills were turned over to the Governor's Legislative Department for review and critique. Now we face the difficult task of getting the bills through two houses of the legislature. We need both your personal support and the \$200 assessment, which many of you have sent, in order to hire the public relations and lobby specialists to complete this legislative approach. Each dollar spent in the achievement of this goal will be worth many dollars later in premium increases which are not needed when the effect of the legislation is transferred into fewer suits.

Last June 30th, our umbrella insurance was going to expire and we were obliged to take the Insurance Commissioner to Monmouth County Superior Court. On that same date, Commissioner Sheeran agreed to approve the policy of the umbrella carrier of our choice to avoid such an appearance.

SECOND SURGICAL OPINION

One of the problems we have just begun to hold meetings on is the study of the effects of screening by consultants on recommended elective surgical procedures. Dr. Eugene G. McCarthy of Cornell University Medical College presented his first findings in the December 19, 1974 article in the *New England Journal of Medicine*. The *New York Times* took this short study of two union programs, one mandatory and one optional presurgical screening, as the last word in exposing "avoidable" or "unnecessary surgery." Actually, much work is yet to be done and Dr. McCarthy now states that he must follow up and study each case which was "unconfirmed."

If the result of further study indicates that much of the "unconfirmed" is merely "deferred" surgery, or the patient is worse off or requires continuous medical care, this program may indeed be a most expensive way of getting at a problem — a problem whose magnitude is variously debated without the benefit of too many facts and no definitive scientific study. Dr. F. J. Ingelfinger (editor, *N Engl J Med*) states, "The study, the first in a series of reports on a new project, was criticized on a number of counts. It did not describe the training of the physicians who recommended elective operation in the first place, it did not take into account the bias of consultants (was their usefulness to the program read off on the meter stick of nonconfirmation?) and, above all, it could provide no evidence that the second opinion was in fact more to the patient's advantage than the first. No justification whatsoever exists for equating a recommendation for operation that is not confirmed with one that is definitely "avoidable" or "unnecessary."

Some consumer and government representatives are interested in this for the cost containment factor. We now know an area which needs more study and I think we are going to get it.

GENERIC

I have appeared on all news media on the topic of generics. In spite of consumer advocate opinion, we feel that it would be impractical to mandate generic prescribing unless some guarantees

could be provided that identical chemical formulas would be used by many pharmaceutical firms. At present, there is a great variance in bioequivalency of drugs with the same generic name and it, therefore, follows that generic prescribing is not in the patients' interest.

During my tenure I have noticed that two allied organizations have been doing particularly good work, and that the work they do accrues to the benefit of both patient care and the good public image of the medical profession. I speak of both our Woman's Auxiliary and our organization of Medical Assistants. It seems to me that both of these organizations have progressed, but I have always been for them and you must make that allowance.

Right now I am immersed with the myriad of meetings and decisions on how best to handle matters. Some of these demand forthright declarations and others necessitate a different approach because public declamation could exacerbate the situation. I am aware that one day I shall look back and this year will seem all rather jolly and character-building, but I am now too close.

I have become so used to dealing with government that I submitted twelve copies of this Annual Report, eight of which had to be legible.

If my philosophy which has guided me through many stormy sessions may be boiled down to a nub, I would say that it was a strong conviction that what exists is not perfect, but that we must strive to build upon the foundation of that already existing system. This includes insurance systems, public and private institutions, and gets right down to such concepts as the doctor-patient relationship. I feel that it would be disastrous to take another approach.

For one whole year a recurrent thought has given me the buoyance, the drive, and the requisite courage to step out and represent the more than nine thousand physicians of this Society on all fronts. This thought is that my peers have granted me, through election, the highest honor possible for any physician in this State. I told you in my incoming address that I

have no reason to paint rosy political pictures for you because I can attain no further or more honored position. I am not going to tell you that I've wrapped up everything in a pretty bow for you. I feel that I have run as good a race as possible over rough terrain and I am ready to pass the stick to the next runner. There is much

yet to be done and I trust you will accord my successor the fine spirit of cooperation you have extended to me. I shall continue to serve in any capacity in which my peers consider me to be of value. I sincerely hope I have served you well.

Filed (page Tr 119)

ACTION TO LIMIT DEBATE

At its first session on Saturday, June 5, 1976, the House of Delegates agreed, upon motion, that no one may speak more than once on any given subject, except by express permission of the House; and that the time be limited to four minutes per speaker, subject to the same exception.

1975 TRANSACTIONS

At its first session on Saturday, June 5, 1976, the House of Delegates approved the Transactions of the 1975 House of Delegates as published in the August 1975 issue of THE JOURNAL and the Transactions of the Special Session of the House of Delegates, December 14, 1975, as published in the February 1976 issue, and distributed to the membership.

Secretary

Arthur Bernstein, M.D., Maplewood

(Reference Committee "A")

The office of the Secretary has continued its usual routines, primarily involving maintenance of membership records, correspondence, telephone inquiries, and completion of numerous questionnaires originating from various sources.

During the administrative year, the Secretary attended the meetings of the Board of Trustees and the several committees of which he is chairman, member, or advisor.

MEMBERSHIP (as of December 31, 1975)

Active: Paid	7,989	
Exempt	702	8,691***
*Associate: Paid	1	
**Affiliate: Paid	47	
Exempt	1	
State Emeritus	402	
Total of Above	9,142	
State Honorary	8	
New and Reinstated Members:		
Active	675	
*Associate	1	
**Affiliate	5	
Transfers within the state	27	
Transfers out-of-state and resignations	91	
Members deceased	112	
Members dropped:		
Active (non-payment of dues)	74	
(N.J. licensure revoked)	2	
(N.J. licensure suspended)	2	
(N.J. licensure voluntarily surrendered)	2	
(N.J. licensure resigned)	1	
*Associate (non-payment of dues)	0	
**Affiliate (non-payment of dues)	1	82

*Associate membership (non-licensed in N.J.) designates Interns and Residents.

**Affiliate membership — physicians who no longer practice in New Jersey.

***Adjusted for transfers out-of-state, resignations, and deaths.

AMA MEMBERSHIP

A total of 7,023 members of The Medical Society of New Jersey maintain active membership in the AMA. The Society's representation in the AMA House of Delegates has risen to a total of eight delegates — one for each thousand members, or fraction thereof.

MEMBERSHIP DIRECTORY

Work is being carried forward to achieve the publication of the next edition of the

Membership Directory in the fall of 1976, when, it is expected, distribution will be made to the entire membership.

The new *Directory* will be printed in the current format, similar to the 1974-75 edition with the following two modifications: (1) restrict each member to a maximum of two (2) office listings, primary and secondary; (2) restrict each member's listing to include only: board certifications, fellowships, county society and AMA membership. The hospital appointments and medical affiliations will be listed as usual.

Otherwise, the new *Directory* will embody the same features as those of the 1974-1975 edition. These include: (1) the presentation in bold print of the "type of practice" in the individual listing directly following the name, and preceding the address; (2) a single asterisk (*) to designate "Armed Forces," a single dagger (†) to designate affiliate membership, a double dagger (††) to designate emeritus membership, and a triple dagger (†††) to designate associate membership; (3) the zip code will appear as the last item in each individual listing; (4) the hospital section of the *Directory* will again include the listings of hospital staffs; (5) the special membership supplement section, which now includes the Constitution and Bylaws of MSNJ, the AMA Principles of Medical Ethics, the Basic Concepts Underlying the Provision of Professional Medical Care, Legal Obligations Affecting Medical Practitioners in New Jersey, Guides for Physician-Hospital Relationships in New Jersey, and a list of Poison Control Centers in New Jersey.

Verification data sheets supplied to the membership will form the basis for the biographical data to be published in the 1976-1977 edition, as did similar data sheets which were supplied to publish the 1974-1975 *Directory*. With the cooperation of the membership, it is the hope of your Committee to make this forthcoming *Directory* the most complete and accurate edition yet published.

Filed (page Tr 120)

Treasurer

Rudolph C. Gering, M.D., Trenton

(Reference Committee "B")

This 1976 interim financial report of your Treasurer has been prepared from the books and records of The Medical Society of New Jersey.

The Balance Sheet is presented as of March 31, 1976 and May 31, 1975. Figures at March 31, 1976 have not been audited, for the reason that the fiscal year of the Society does not end until May 31, 1976. The figures at May 31, 1975 have been abstracted from the report of audit dated August 21, 1975.

The Statement of Revenue, Expenditures, and General Surplus Unappropriated presents the transactions of the Society for the ten months ended March 31, 1976 and the year ended May 31, 1975.

Revenues have been examined on a test basis and disbursements have been test-checked to approve supporting vouchers by the Society's in-

dependent accountants. The cash balances at March 31, 1976 were reconciled with the bank statements but were not confirmed directly with the depositories. Revenues from Counties for dues assessments were checked in detail to reports on file, but were not confirmed with County Treasurers at this time. Investments were not physically examined or confirmed at March 31, 1976.

These financial statements have been prepared in a form similar to the annual audit report, in order to show in greater detail the assets, liabilities, fund balance, operating revenue, and expenditures of the Society, in conformity with Resolution #28 approved by the 1968 House of Delegates under the heading "Annual Financial Report."

Filed with commendation to the Treasurer (page Tr 121)

BALANCE SHEET—GENERAL FUND

Assets	March 31, 1976 (Unaudited)	May 31, 1975 (Audited)
Cash (Overdraft) (Page Tr 15)	\$ (275,535.97)	\$ 70,745.21
General Fund Investment Account — at cost (Page Tr 15)	260,000.00	420,000.00
General Fund Investment Portfolio — at cost (Page Tr 16)	189,709.38	139,725.00
General Fund Saving Certificates (Page Tr 15)	763,392.89	40,000.00
Mark IV Investment Account (Page Tr 16)	41,009.65	39,500.00
Accounts Receivable	4,613.24	18,711.66
Inventories — at cost		
Maternity Service Record Books	4,270.56	4,992.16
<i>The Healing Art Books</i>	3,754.16	3,754.16
Land, Building and Equipment — at cost	327,391.17	327,391.17
Deferred Expense — Construction Loan	55,500.00	63,000.00
Accrued Interest	7,980.65	7,787.88
Due from New Jersey Foundation for Health Care Evaluation	602.57	—0—
Other Assets	—0—	1,629.84
Total Assets	\$1,382,688.30	<u>\$1,137,237.08</u>

LIABILITIES AND FUND BALANCES

Liabilities:		
Unexpended Budget Appropriations (Page Tr 11)	\$ 145,120.09	\$ —0—
Accounts Payable	19,078.66	55,463.23
Payroll Taxes Payable	3,222.61	1,860.07
Due to Physicians' Relief Fund	42,220.41	40,209.91
Due to Medical Student Loan Fund	55,500.00	63,000.00
Due to New Jersey Foundation for Health Care Evaluation	2,520.00	—0—
Deferred Income — Assessments Collected		
Applicable to Succeeding Fiscal Year (Page Tr 14)	398,868.75	354,835.84
AMA Voluntary Collection	30.00	7,550.00
Other Liabilities	2,227.88	6,402.09
Funds for Specific Purposes:		
House Restoration and Replacement	9,339.24	9,339.24
Land, Building and Equipment	327,391.17	327,391.17
Maternity Service Record Books	4,270.56	4,992.16
Royalties on <i>The Healing Art</i>	925.50	925.50
<i>The Healing Art</i> (books)	2,828.66	2,828.66
Membership Directory	5,805.08	3,600.08
Annual Meeting	17,078.98	—0—
Training Program for Emergency Physicians & Nurses	—0—	1,976.67
Voluntary Assessment Professional Liability	103,593.40	—0—
AMA Dues	46,750.00	—0—
General Fund Balance (Unappropriated)	195,917.31	256,862.46
Total Liabilities and Fund Balances	\$1,382,688.30	<u>\$1,137,237.08</u>

STATEMENT OF REVENUE, EXPENDITURES AND GENERAL FUND BALANCE (UNAPPROPRIATED)

	Ten Months Ended March 31, 1976 (Unaudited)	Year Ended May 31, 1975 (Audited)
Revenue:		
Assessments Earned (Page Tr 14)	\$688,744.59	\$644,526.06
Interest Income from General Fund		
Investments (Page Tr 15)	9,184.74	6,378.43
Interest Income from General Fund		
Savings Certificates (Page Tr 15)	5,510.81	13,506.61
Interest Income from General Fund		
Investment Portfolio (Page Tr 16)	10,711.67	14,466.80
Interest Income from Mark IV Investment (Page Tr 16)	1,807.66	149.73
Maternity Service Record Book Sales	744.56	1,050.18
<i>The Healing Art</i> Book Sales		25.50
Building Rent Income	2,852.80	
Miscellaneous Income		808.07
Interest Income on AMA Dues		6,716.26
Total Revenue	\$719,556.83	<u>\$687,627.64</u>
Expenditures — Budget Appropriation		
(12 months) — (Page Tr 11)	\$734,412.00	\$568,022.91
Excess of Expenditures over Revenue or	(\$ 14,855.17)	
Excess of Revenue over Expenditures before		
Medical Journal Deficit and other Expenditures		\$119,604.73
Other Activities and Expenditures:		
Medical Journal Deficit (Page Tr 13)	(\$ 46,401.31)	(\$ 39,350.84)
Annual Meeting Deficit		(17,565.13)
Prior Year's Income and Expenditures — in current year	311.33	(227.98)
	(\$ 46,089.98)	<u>(\$ 57,143.95)</u>
Net Increase (Decrease) in Fund Balance		
Unappropriated from Operations	(\$ 60,945.15)	\$ 62,460.78
General Fund Balance (Unappropriated):		
Balance, Beginning	\$256,862.46	<u>\$194,401.68</u>
Balance, Ending	\$195,917.31	<u>\$256,862.46</u>

STATEMENT OF EXPENDITURES—GENERAL FUND
FOR THE TEN MONTHS ENDED MARCH 31, 1976
(UNAUDITED)

Account	Adopted Budget	Total Expended	Balance Unexpended
Executive Salaries	\$113,097.00	\$ 96,924.10	\$ 16,172.90
General Staff Salaries	234,255.33	185,723.41	48,531.92
General Executive Office Expense	32,000.00	28,656.35	3,343.65
Executive Travel	7,600.00	6,768.09	831.91
House Maintenance	34,400.00	31,120.76	3,279.24
Treasurer	9,900.00	8,645.20	1,254.80
Finance & Budget Committee	75.00	1.52	73.48
Secretary	400.00	25.30	374.70
Salary Taxes	20,034.67	15,186.01	4,848.66
Insurance	18,500.00	17,485.15	1,014.85
House Reserve	9,200.00	12,301.70	(3,101.70)
MSNJ Pension Plan	4,200.00	4,052.44	147.56
MSNJ Building Loan	12,800.00	10,650.00	2,150.00
AM-CAP Computer Program	24,000.00	4,574.45	19,425.55
Legislation	7,000.00	6,298.42	701.58
Council on Public Health	5,400.00	2,313.05	3,086.95
Council on Public Relations	35,300.00	36,248.49	(948.49)
Council on Medical Services	750.00	416.30	333.70
Council on Mental Health	1,700.00	433.76	1,266.24
President & Presidential Officers	17,800.00	13,329.41	4,470.59
AMA Delegates	24,400.00	25,945.80	(1,545.80)
Woman's Auxiliary	6,300.00	5,488.16	811.84
Committee on Medical Education	30,500.00	13,363.83	17,136.17
Conference Groups	500.00	19.13	480.87
Membership Directory	20,000.00	16,377.36	3,622.64
Committee on Emergency Medical Care	10,400.00	10,387.61	12.39
Credentials & Membership Committee	1,200.00	1,199.60	.40
Archives & History	1,000.00	223.70	776.30
Committee on Medical Defense & Insurance	700.00	466.25	233.75
Membership Inquiry & Complaint Committee	1,000.00	154.64	845.36
Board of Trustees	9,000.00	4,248.29	4,751.71
Contingent	10,000.00	14,053.44	(4,053.44)
Judicial Council	1,000.00	229.48	770.52
Legal	13,000.00	5,712.45	7,287.55
Medical Student Loan Fund	6,000.00	6,000.00	—0—
Authorized Reimbursement for			
Representatives to Meetings	5,000.00	4,268.26	731.74
Physicians' Relief Fund	6,000.00		6,000.00
Total Budget Expenditures	\$734,412.00	\$589,291.91	<u>\$145,120.09</u>

BALANCE SHEET
MEDICAL STUDENT LOAN FUND

Assets	Ten Months Ended March 31, 1976 (Unaudited)	Year Ended May 31, 1975 (Audited)
Cash (Page Tr 15)	\$ 8,552.35	\$ 3,635.45
Certificates of Deposits (Page Tr 16)	113,000.00	135,000.00
Notes Receivable — Secured by		
Life Insurance Policies Assigned	277,010.52	243,744.00
Due from General Fund	55,500.00	63,000.00
Accrued Interest	1,002.95	864.22
Loans Receivable — General Fund	10,650.00	—0—
Fund Balance	<u>\$465,715.82</u>	<u>\$446,243.67</u>

Note: The Fund balance includes \$7,612 designated as the Albert Barker Kump Memorial Grant and \$5,055 designated as the Joseph E. Mott Memorial Grant.

STATEMENT OF REVENUE AND FUND BALANCE
MEDICAL STUDENT LOAN FUND

	Ten Months Ended March 31, 1976 (Unaudited)	Year Ended May 31, 1975 (Audited)
Revenue:		
Contributions:		
General	\$ 4,415.80	\$ 3,650.65
Albert Barker Kump Memorial Grant	250.00	250.00
General Fund Contribution	6,000.00	—0—
Income from Investments	2,723.50	6,514.40
Income from Certificates of Deposit	2,752.63	1,279.52
Interest on Notes Receivable	180.22	343.67
Interest on Loans Receivable — General Fund	3,150.00	4,320.00
Bad Debt Recovery	—0—	89.96
Total Revenue	\$ 19,472.15	\$ 16,448.20
Fund Balance, Beginning	\$446,243.67	\$429,795.47
Fund Balance, Ending	\$465,715.82	<u>\$446,243.67</u>

BALANCE SHEET
PHYSICIANS' RELIEF FUND

	Ten Months Ended March 31, 1976 (Unaudited)	Year Ended May 31, 1975 (Audited)
Assets		
Cash (Page Tr 15)	\$ 50.00	\$ 550.00
Loan Receivable	500.00	—0—
Due from General Fund	42,220.41	40,209.91
Fund Balance	\$42,770.41	\$40,759.91

STATEMENT OF REVENUE AND FUND BALANCE
PHYSICIANS' RELIEF FUND

	Ten Months Ended March 31, 1976 (Unaudited)	Year Ended May 31, 1975 (Audited)
Revenue:		
Income from Investments	\$ 2,010.50	\$ 2,307.16
Contributions	—0—	50.00
Total Revenue	\$ 2,010.50	\$ 2,357.16
Grants (Expense)	—0—	2,500.00
Net Revenue	\$ 2,010.50	\$ 142.84
Fund Balance, Beginning	\$40,759.91	\$40,902.75
Fund Balance, Ending	\$42,770.41	<u>\$40,759.91</u>

STATEMENT OF REVENUE AND EXPENDITURES
MEDICAL JOURNAL

	Ten Months Ended March 31, 1976 (Unaudited)	Year Ended May 31, 1975 (Audited)
Revenue:		
Members' Subscriptions Earned	\$ 36,275.00	\$ 39,159.25
Advertising:		
State Medical Journal Advertising Bureau	574.80	35,611.47
United Media Associates	43,858.23	—0—
Local	14,947.80	18,780.76
Classified	474.65	676.50
Cooperative Rebate	1,234.55	1,091.92
Subscriptions and Extra Copies	1,879.99	2,004.78
Reprints — Net	311.73	1,198.78
Illustrations	—0—	896.93
Total Revenue	\$ 99,556.75	<u>\$ 99,420.39</u>
Expenditures:		
Publication	\$ 93,113.97	\$ 89,583.20
Salaries	28,750.93	30,152.50
Advertising Manager's Commission	8,044.75	6,000.00
Commissions — Local	11,543.21	7,447.72
Discounts	1,106.62	831.01
Payroll Taxes	1,830.26	2,053.59
Insurance	25.00	25.00
Travel	429.37	—0—
Illustrations	—0—	1,221.68
Office	69.45	101.16
Bad Debts	1,044.50	667.00
Administrative Expenses	—0—	688.37
Total Expenditures	\$145,958.06	<u>\$138,771.23</u>
Excess of Expenditures Over Revenue	\$ 46,401.31	<u>\$ 39,350.84</u>

SCHEDULE OF STATE ASSESSMENTS COLLECTED
FOR THE TEN MONTHS ENDED MARCH 31, 1976
(UNAUDITED)

County	1976 Dues	1975 Dues	Net State Assessments
Atlantic	\$ 16,280.00	\$ 2,620.00	\$ 18,900.00
Bergen	101,530.00	4,200.00	105,730.00
Burlington	24,080.00	870.00	24,950.00
Camden	49,980.00	1,580.00	51,560.00
Cape May	3,410.00	200.00	3,610.00
Cumberland	13,090.00	700.00	13,790.00
Essex	135,300.00	6,765.00	142,065.00
Gloucester	10,780.00	410.00	11,190.00
Hudson	30,640.00	5,175.00	35,815.00
Hunterdon	5,830.00	100.00	5,930.00
Mercer	23,210.00	16,830.00	40,040.00
Middlesex	42,150.00	1,010.00	43,160.00
Monmouth	47,430.00	7,870.00	55,300.00
Morris	40,810.00	3,115.00	43,925.00
Ocean	18,260.00	2,630.00	20,890.00
Passaic	70,410.00	3,785.00	74,195.00
Salem	4,730.00	—0—	4,730.00
Somerset	13,330.00	1,310.00	14,640.00
Sussex	6,490.00	300.00	6,790.00
Union	68,850.00	550.00	69,400.00
Warren	7,150.00	320.00	7,470.00
Total	\$733,740.00	\$60,340.00	<u>\$794,080.00</u>

RECONCILIATION OF STATE ASSESSMENT ACCOUNT
FOR THE TEN MONTHS ENDED MARCH 31, 1976
(UNAUDITED)

Unearned Assessments, June 1, 1975		\$354,835.84
Collections — 1975 Members' and Affiliate Members' Dues	\$ 60,340.00	
Less: Annual Meeting Assessment	\$ 1,482.50	
Medical Journal Assessment	2,965.00	
N.J. Foundation for Health Care Evaluation Assessment	<u>6,890.00</u>	
	<u>\$ 11,337.50</u>	
		\$ 49,002.50
Collections — 1976 Members' and Affiliate Members' Dues	\$733,740.00	
Less: Annual Meeting Assessment	\$16,655.00	
Medical Journal Assessment	<u>33,310.00</u>	
	<u>\$ 49,965.00</u>	
		\$683,775.00
Less: 1976 Assessments Applicable to Year Ending May 31, 1976 — (\$683,775.00 x 7/12)	<u>\$398,868.75</u>	
		<u>\$284,906.25</u>
Earned Assessments for the Ten Months Ended March 31, 1976		<u><u>\$688,744.59</u></u>

SCHEDULE OF SPECIAL ASSESSMENTS COLLECTED
FOR THE TEN MONTHS ENDED MARCH 31, 1976
(UNAUDITED)

County	American Medical Association Dues
Atlantic	\$ 29,095.00
Bergen	123,265.00
Burlington	35,360.00
Camden	90,440.00
Cape May	6,000.00
Cumberland	15,500.00
Essex	230,850.00
Gloucester	20,610.00
Hudson	44,170.00
Hunterdon	3,110.00
Mercer	55,885.00
Middlesex	71,795.00
Monmouth	50,145.00
Morris	54,925.00
Ocean	23,880.00
Passaic	69,190.00
Salem	10,000.00
Somerset	20,605.00
Sussex	7,970.00
Union	97,885.00
Warren	14,080.00
Total	<u><u>\$1,074,760.00</u></u>

RECONCILIATION OF SPECIAL ASSESSMENTS
FOR THE TEN MONTHS ENDED MARCH 31, 1976
(UNAUDITED)

	American Medical Association
Balance Payable, June 1, 1975	\$ 3,080.00
Assessments Collected per above Schedule	1,074,760.00
	<u>\$1,077,840.00</u>
Remitted to AMA	1,031,090.00
Balance Payable, March 31, 1976	<u>\$ 46,750.00</u>

ANALYSIS OF CASH, CERTIFICATES OF DEPOSIT, INVESTMENTS
AND INCOME THEREON MARCH 31, 1976
(UNAUDITED)

General Fund:	
New Jersey National Bank:	
Treasurer's General Checking (Overdraft)	\$276,035.97
Office Petty Cash Fund	<u>500.00</u>
Total (Overdraft)	<u>\$275,535.97</u>
Medical Student Loan Fund:	
New Jersey National Bank:	
Treasurer's Checking Account	<u>\$ 8,552.35</u>
Physicians' Relief Fund:	
New Jersey National Bank:	
Treasurer's Checking Account	<u>\$ 50.00</u>

ANALYSIS OF GENERAL FUND INVESTMENTS AND INCOME THEREON
MARCH 31, 1976
(UNAUDITED)

	Due Date	Cost	Maturity Value	Yield	Interest Income
New Jersey National Bank:					
Certificate of Deposit					
#5658	4/14/76	\$ 75,000.00	\$ 75,000.00	5.5%	\$ 858.91
#5666	4/21/76	75,000.00	75,000.00	5.5%	779.79
#5672	5/03/76	75,000.00	75,000.00	5.5%	768.49
#5682	5/13/76	35,000.00	35,000.00	5.5%	247.88
		<u>\$260,000.00</u>	<u>\$260,000.00</u>		\$ 2,655.07
Income from Investments redeemed during period					\$ 8,540.17
					\$11,195.24
Less: Interest Income on Physicians' Relief Fund					\$ 2,010.50
General Fund Investment Income					<u>\$ 9,184.74</u>

ANALYSIS OF GENERAL FUND SAVINGS CERTIFICATES AND
INCOME THEREON
MARCH 31, 1976
(UNAUDITED)

	Cost	Yield	Interest Income
Trenton Savings Fund:			
Certificate #10-8427	\$ 20,000.00	6%	\$ 996.67
Certificate #11-8428	20,000.00	6.75%	1,121.25
New Jersey National Bank:			
Account #01-19-174556	723,392.89	5%	3,392.89
General Fund Savings Certificates Income			<u>\$5,510.81</u>

ANALYSIS OF INVESTMENT PORTFOLIO AND INCOME THEREON
MARCH 31, 1976
(UNAUDITED)

Description	Due Date	Yield	Cost	Maturity Value	Interest Income
Federal Home Loan Bank	5/25/76	7.2%	\$ 19,962.50	\$ 20,000.00	\$ 1,200.00
Federal Home Loan Bank	5/25/76	7.2%	39,950.00	40,000.00	2,400.00
U.S. Treasury Bills	5/31/76	6%	20,000.00	20,000.00	999.69
U.S. Treasury Bills	5/31/76	6%	20,000.00	20,000.00	929.71
U.S. Treasury Note	7/31/77	7½%	40,000.00	40,000.00	2,000.00
Bank for Coops	4/04/77	7.7%	49,796.88	50,000.00	1,941.55
			<u>\$189,709.38</u>	<u>\$190,000.00</u>	<u>\$ 9,470.95</u>
Income from Investments					
Redeemed during period					<u>1,240.72</u>
Investment Portfolio Income ..					<u>\$10,711.67</u>

ANALYSIS OF MEDICAL STUDENT LOAN FUND INVESTMENT
ACCOUNT AND INCOME THEREON
MARCH 31, 1976
(UNAUDITED)

	Due Date	Yield	Cost	Maturity Value	Interest Income
New Jersey National Bank:					
Certificate of Deposit					
#5625	4/07/76	5½%	\$ 25,000.00	\$ 25,000.00	\$ 312.67
#5665	4/21/76	5½%	30,000.00	30,000.00	311.92
#5675	4/28/76	5½%	8,000.00	8,000.00	74.74
#5679	5/05/76	5½%	15,000.00	15,000.00	124.31
#5687	5/26/76	5½%	35,000.00	35,000.00	179.31
			<u>\$113,000.00</u>	<u>\$113,000.00</u>	<u>\$ 1,002.96</u>
Income from Investments					
Redeemed during period					<u>4,473.17</u>
Total Interest from Investments					<u>\$ 5,476.13</u>

ANALYSIS OF MARK IV INVESTMENT ACCOUNT
AND INCOME THEREON
MARCH 31, 1976
(UNAUDITED)

	Cost	Maturity Value	Interest Income
Mark IV Investment	<u>\$ 39,500.00</u>	<u>\$ 41,009.65</u>	<u>\$ 1,807.66</u>

Board of Trustees

James S. Todd, M.D., Chairman, Ridgewood

(Reference Committee "A")

The Board of Trustees is the executive arm of the Medical Society, and by virtue of its position must decide on many issues that are largely unknown to the general membership. Being so cast, it is inevitable that not all decisions and actions will be viewed with approval by the membership. Democracy by its very nature concludes that at any given time there will be elements of dissatisfaction. That this occurs is less important than the fact that vocal dissatisfaction by an obvious minority leads to divisiveness.

Divisiveness may be the most lethal of diseases to which the Medical Society is exposed. Leadership is no easy task, and the membership should appreciate that they have elected a Board that is dedicated, knowledgeable, and not afraid to make the contemporarily unpopular decision in order to achieve, hopefully, the greater long-term benefit.

The complexity and number of issues with which the Board deals each year increase steadily, and in the aggregate are beyond the ken of any causal observer. The Board desires to represent the membership with utmost vigor, but in order to do that requires a certain responsibility and restraint on the part of the membership. If organized medicine in general and MSNJ in particular are to have any meaningful impact, it is essential that decisions be rendered without fear of constant contradiction. If the track record of the Board is such that a majority of the membership are dissatisfied, then it is the membership's responsibility to change the composition of the Board. Public carping and splinter-group activity can do nothing but dilute the effectiveness of the Society's activities.

The following is a list of some of the items that have occupied the Board's attention this year and are presented for your information.

Filed (page Tr 119)

EIGHTH AMA DELEGATE AND ALTERNATE DELEGATE

(Reference Committee "A")

Because of increased membership in the American Medical Association from New Jersey, MSNJ is now entitled to eight delegates and eight alternate delegates.

Elected to serve as the eighth delegate was James S. Todd, M.D., and Howard D. Slobodien, M.D., was elected the alternate delegate.

Filed (page Tr 119)

INVITED GUESTS

(Reference Committee "A")

This year, the established policy of inviting presidents and executive secretaries/executive directors of component societies to attend Board meetings has been extended to include the presidents of New Jersey specialty societies.

Filed (page Tr 120)

POLICY STATEMENT ON SUPPORT OF LITIGATION INSTITUTED BY SPECIALTY SOCIETIES

(Reference Committee "A")

The Board adopted the following Policy Statement on Support of Litigation Instituted by Specialty Societies:

The Medical Society of New Jersey will not, without prior authorization by the Board of Trustees or the Executive Committee, become a party plaintiff to any litigation nor sustain a financial commitment in support thereof.

Each and every situation must, of necessity, be evaluated on an ad hoc basis.

It is understood that in order to secure the support of The Medical Society of New Jersey the specialty society in question shall have received the prior concurrence of the Executive Committee or the Board of Trustees of The Medical Society of New Jersey.

Filed (page Tr 120)

COMPONENT AND SPECIALTY SOCIETY
LEGAL AND LEGISLATIVE ACTIVITIES
(Reference Committee "E")

On occasion, the Board of Trustees has received requests from component societies and specialty societies to participate in and support litigation and/or legislation filed or developed by the component or specialty societies. The issues are often complicated and timing is a critical factor in matters of this nature.

In an effort to represent our membership to the fullest extent of our ability, the Board of Trustees has requested that specialty societies and component societies that are desirous of MSNJ support contact the Board prior to the institution of suit or the introduction of legislative measures.

Filed (page Tr 125)

AMENDMENT OF MEDICAID LEGISLATION
(Reference Committee "F")

This resolution, submitted by the New Jersey Delegation to the AMA, called upon the AMA to work toward changing Title XIX to include, in addition to customary charges, reimbursement for necessary and essential "items consumed by or issued to the patient," and that the AMA Council on Legislation seek to promote these changes in Title XIX. The resolution also requested that the AMA declare a belief that quality medical care cannot be obtained by legislation which effects dual standards of care.

The AMA House voted to reject this resolution.

Filed (page Tr 128)

FEDERAL CATASTROPHIC HEALTH INSURANCE
(Reference Committee "F")

At the June meeting of the AMA House of Delegates, the House adopted a substitute resolution calling for support of the Comprehensive Health Care Insurance Act of 1975. The "resolved" portion of the substitute resolution reads as follows:

Resolved, that it be the policy of the American Medical Association to support enactment of HR 6222, the Comprehensive Health Care Insurance Act of 1975; and be it further

Resolved, that catastrophic coverage represents the area where assistance in health care coverage is most needed; and be it further

Resolved, that the AMA at this time actively support the catastrophic coverage philosophy, preferably through private insurance carriers.

Filed (page Tr 128)

FEDERAL REGULATIONS MANDATING HOSPITAL
UTILIZATION OR PEER REVIEW PROCEDURES
(Reference Committee "F")

At the last Annual Meeting, the House of Delegates adopted Resolution #32 (Federal Regulations Mandating Hospital Utilization or Peer Review Procedures), which called upon the American Medical Association to adopt the position that Federal regulations mandating hospital utilization or peer review procedures be applied uniformly to all hospitals, including city, county, state, public health, and VA hospitals.

During the 1975 Annual Convention held in Atlantic City, the AMA House reaffirmed Resolution #107 (A-74) in lieu of this Resolution. Resolution #107 establishes the position that peer review in Federal institutions is needed and desirable and that they should also be subject to JCAH review.

Filed (page Tr 128)

FEDERAL UTILIZATION REVIEW REGULATIONS
(Reference Committee "F")

The House of Delegates voted at the 1975 Annual Meeting to notify the AMA of the Society's vigorous support of the lawsuit authorized by the Board of Trustees of the AMA challenging the Utilization Review Regulations proposed by HEW that were to be implemented on July 1.

The Secretary of HEW entered a stipulation agreement with the AMA whereby the contested Utilization Review Regulations would be withdrawn and amended to comply with AMA recommendations.

The AMA suit, therefore, was dismissed without prejudice.

Filed (page Tr 128)

HOSPITAL APPLICATION FORMS FOR
PRESENT AND NEW STAFF MEMBERS
(Reference Committee "F")

At its July meeting, the Board directed that notice of opposition to the application form for appointment to medical staffs be transmitted to the Joint Commission on Accreditation of Hospitals and the New Jersey Hospital Association.

Reply has been received from the Joint Commission on Accreditation of Hospitals stating that the copy of the Briggs Corporation form for delineation of privileges and application for staff membership is not a Commission form nor is the use of the form required by the Joint Commission on Accreditation of Hospitals. The requirements for medical staff selections are contained in the interpretive language of Standard III of the Medical Staff Section in the *Accreditation Manual for Hospitals*—1970, Updated 1973 and amended in March 1975.

The application form was distributed to the Board for review. The most objectionable portion of the form was discussed. This section states:

I hereby further authorize and consent to the release of information by this hospital, or its medical staff, to other hospitals, medical associations, and other interested persons, on request, regarding any information the hospital and the medical staff may have concerning me, as long as such release of information is done in good faith and without malice, and I hereby release from liability this hospital and its staff for so doing.

The Board voted to offer appropriate support to any member of this Society being denied hospital staff privileges or having such privileges revoked for refusing to sign this type of application form.

The New Jersey Hospital Association agreed to notify its membership that forms incorporating blanket releases of patient and medical records are not endorsed by the New Jersey Hospital Association or MSNJ.

At the AMA Clinical Convention, the New Jersey Delegation submitted a resolution calling upon the AMA to oppose the use of medical staff application forms that grant hospital representatives blanket permission to inspect all

medical records of the applying physician in the custody of other hospitals where he has had staff privileges.

The AMA House adopted the following amended resolution:

Resolved, that the American Medical Association House of Delegates record itself as opposing the use and implementation of medical staff application forms which grant hospital representatives blanket permission to inspect all medical records of the applying physician; and be it further

Resolved, that it is proper for the medical staff Credentials Committee to investigate the past performance of any applicant for staff membership in order to determine his qualifications for the privileges requested, provided that such investigation does not violate confidentiality of patient information.

Filed (page Tr 128)

INDEPENDENT PHYSICIANS' ASSOCIATIONS AND/OR
PREPAID HEALTH CARE CONTRACTS
(Reference Committee "F")

The Board voted to endorse a resolution submitted by the New Jersey Foundation for Health Care Evaluation calling upon MSNJ to develop, through the Foundation, and in cooperation with the component societies, a proposal for the establishment of one or more independent physicians' associations and/or a prepaid health care contract.

Filed (page Tr 128)

MAJOR AND MINOR SURGERY
(Reference Committee "F")

The Ad Hoc Committee on Surgical Assistants met on February 25, 1976, at the Executive Offices of The Medical Society of New Jersey. At that time the Committee considered the proposed regulation concerning major and minor surgery that was printed in the January issue of the *New Jersey Register*. The Committee was broadly based and representative of nine different medical and surgical specialties.

Consideration was given to the State Board of Medical Examiners' proposal as well as the position of the Joint Commission on Accreditation of Hospitals and that of the American College of Surgeons.

Nationally, no major medical organizations, including JCAH, ACS, AMA, and AAMC have been able to define the terms "major and minor surgery." Consequently, most of these organizations have abandoned the use of the term. Likewise, there is no generally accepted definition of "unusual hazard." According to JCAH Guidelines, each hospital must determine its own definition and document it in the rules and regulations of the medical staff. The conscience of the surgeon, the operating room supervisor, and the medical staff will be reflected in the definition and its interpretation. The surgeon must be prepared to defend his decisions before the tissue committee, the medical staff, and the governing body of the hospital.

To the Committee's knowledge, no state has a rule on the topic or a requirement that goes beyond compliance with the JCAH Guidelines. The necessity for a rule in the form offered by the State Board of Medical Examiners was not, in the opinion of the Committee, well documented.

The Committee determined that a regulation of workable proportions is necessary and developed the following:

Except in dire emergencies, in any surgical procedure with unusual hazard to life there must be a qualified assistant present and scrubbed.

The term "qualified assistant" is to be defined in the rules and regulations of the hospital.

It shall be the responsibility of each medical staff to promulgate appropriate rules and regulations in this regard and to assure compliance by the individual physicians.

The Board approved the statement that was developed by the Committee. This statement will be presented to the representatives of the State Board of Medical Examiners when it meets with the Ad Hoc Committee on Surgical Assistants.

Filed (page Tr 128)

NATIONAL HEALTH PLANNING AND RESOURCES DEVELOPMENT ACT OF 1974 (Reference Committee "F")

The AMA House of Delegates in June voted to

adopt a resolution strongly supporting the AMA Board of Trustees in any action, including legal action, they deem appropriate and effective in preventing the implementation of PL 93-641 (National Health Planning and Resources Development Act of 1974).

Filed (page Tr 128)

POSITION STATEMENT OF HSA AREA DESIGNATIONS

(Reference Committee "F")

Meeting on October 19, 1975, the Board adopted the following official position on HSA area designations:

(a) That the formation of HSA's be democratically generated from the community in line with the following points:

(1) That county councils, which are broadly representative of the population, be established in each county with professional providers designated by the various health care professional associations, or societies operating in the county, including, but not limited to, medical, osteopathic, optometric, podiatric, nursing, physical therapy, speech therapy, hospital administrators' associations.

(2) That these county health care councils elect representatives to a central agency to be known as the Health Systems Agency of the area in which the counties are located, and these elected representatives constitute the Agency's Board of Directors, such elections to be made on an equitable basis, considering the geographical and population characteristics of the area served.

(3) That consumer members of the county councils, represent county-wide civic, patriotic, business, religious and other societies or associations, so that each consumer member, in fact, does represent an identifiable group within the county and is not merely a selectee of a central self-perpetuating group of persons, however well motivated it may seem at present.

(4) That county councils prescribe the manner or method of admitting to its membership individual citizens who are not representatives of county-wide groups.

(b) That competing agencies not decide upon which agency shall ultimately be selected;

(c) That the practicing physicians' opinions and input shall be maximum in the formative stages;

(d) That the decision as to formation of the HSA shall be based upon community acceptance rather than decisions of agencies with a vested interest.

Filed (page Tr 128)

POSITION STATEMENT ON THE PRACTICE OF
RADIOLOGY

(Reference Committee "F")

The Medical Society of New Jersey recognizes the fee-for-service payment as an integral factor in the private practice of medicine.

The practice of radiology is a component of the practice of medicine in the same category as the practice of surgery, internal medicine, pediatrics, family medicine, or any other discipline or designated field of medicine.

Therefore, the Board of Trustees of The Medical Society of New Jersey supports the efforts of the Radiological Society of New Jersey and urges Blue Cross and Blue Shield to work with the Radiological Society so that where indicated, the professional component of in-hospital radiological services would be covered by the Medical-Surgical Plan in a manner similar to other physician services.

Following an unsuccessful meeting with the Commissioner of Insurance concerning the right of radiologists to practice under a fee-for-service format, the Radiological Society of New Jersey determined that it would be necessary to litigate this issue. (Mr. Maressa and Doctor McGuire attended this meeting). The Executive Committee, meeting on October 29, considered a request from the Radiological Society to support the suit and underwrite a portion of the legal expenses.

The Executive Committee voted to take the following action:

Support the Radiological Society of New Jersey in its suit against the Commissioner of Insurance and Blue Cross-Blue Shield; and to underwrite one-half the legal expenses incurred thereto with MSNJ's commitment not to exceed \$2,500.

Suit was filed on October 30, 1975.

Filed (page Tr 128)

PROPOSED SHARED HEALTH CARE FACILITIES
REGULATIONS

(Reference Committee "F")

The Commissioner of Institutions and Agencies

proposes to establish rules and regulations regarding shared health care facilities. These rules will establish definitions and conditions of Medicaid participation for shared health care facilities.

Prior to the March 21 meeting of the Board, each member was requested to submit his comments on the proposed rules to the Executive Director.

The Executive Director reported that the consensus of those Trustees responding was that these rules and regulations are not desirable, for the following reasons:

(a) Every partnership — regardless of whether or not it is multi-discipline would be covered;

(b) Only the solo practitioner in his own building would be excluded;

(c) Every professional office building and multiple office structure in the State, regardless of whether or not there is any connection between providers, would be covered;

(d) How would a physician who rents an office in a fifty-office complex be able to provide the State with the name and address of every person and entity having a financial interest in the structure?; and

(e) How could a physician gain access to a listing of all lease holders and tenants?

The Board sent a communication to the Division of Medical Assistance and Health Services indicating that the Society feels that the mechanism being employed is a destructive and unbelievably costly exercise at over-regulation with no apparent good to be served on behalf of the recipients of Medicaid or the taxpayers of the state. The regulation as proposed is absolutely unworkable and will have the effect of removing all but the physicians in solo practice from the Medicaid Program.

Filed (page Tr 128)

PROPOSED STANDARDS FOR LICENSURE OF
AMBULATORY CARE FACILITIES
(Reference Committee "F")

The proposed standards prepared by the State Department of Health for licensure of free-standing ambulatory care programs and facilities include the following:

- (a) A facility providing primary care to adults and children.
- (b) A facility providing comprehensive pediatric care.
- (c) A facility providing family planning services.
- (d) A facility providing prenatal and postpartum care.
- (e) A facility providing surgical services.
- (f) A facility providing drug abuse treatment services.

Hospital-based facilities must meet the standards promulgated in the hospital licensure manual of the New Jersey State Department of Health.

Facilities providing a single diagnostic service or a single therapeutic modality other than those enumerated above will not be licensed at the present time. This is not an all-inclusive list of the potential ambulatory care facilities which may be licensed. Standards will be developed as the need arises.

These standards and regulations are promulgated in order to insure health and medical service to the people residing in the State of New Jersey. The intent, whenever possible, is to provide personal comprehensive health services with due regard for patient amenities.

The Society sent a communication to the Commissioner of Health requesting that the proposals not be enacted, that they be amended, and that a public hearing be held. It was also recommended that no further action be taken until the Federal regulations concerned with the State Health Planning Agencies, State Health

Coordinating Councils, Certificate of Need, and the revised amendments related to Section 1122 are published.

Filed (page Tr 129)

REPEAL EARNINGS TEST FOR SOCIAL SECURITY
(Reference Committee "F")

Resolution #3 from the 1975 House of Delegates called upon the American Medical Association actively to support the passage of United States Senate Bill 410 to allow retired citizens receiving Social Security retirement benefits to earn unlimited income after age 65 without being penalized.

The AMA House of Delegates voted in June to adopt the resolution submitted by the New Jersey Delegation.

Filed (page Tr 129)

AD HOC COMMITTEE ON BLOOD PROCUREMENT
(Reference Committee "G")

Because of constantly changing events, the final report of the Ad Hoc Committee on Blood Procurement is not yet completed. The complexities of the situation and the reluctance of the blood banks to organize cooperatively make it extremely difficult to render a report that will have any meaning or effective results.

Filed with comment (page Tr 130)

Supplemental Report #1

JOINT PRACTICE COMMITTEE WITH THE
NEW JERSEY STATE NURSES' ASSOCIATION

William J. D'Elia, M.D., Chairman, Spring Lake
(Reference Committee "A")

This Committee of physicians and nurses was established in 1973 as an Ad Hoc of the National Joint Practice Committee of the American Medical Association and the American Nurses' Association. The major objective of our Com-

mittee is to clarify the physician-nurse role in order to meet health-care needs and interpret the expanded role of the nurse as called for in the Surgeon General's report, "Extended Role for Nurses."

The goal of the Committee in 1974-75 was to establish joint practice committees in each New Jersey health agency. Guidelines for establishing such a committee were sent to 158 hospital facilities. Along with the literature, a questionnaire was included asking if there was a committee in the hospital or if they were planning on having one. The response to the questionnaire showed that out of 44 returns, 24 had a joint practice committee, 9 had none, and 11 had a patient care committee or medical liaison committee.

A "how to" demonstration workshop was held for six health facilities in Monmouth County in April 1975. A follow-up is planned in 1976.

Two position papers were prepared. The "Role of the Committee" was forwarded to the Department of Education, Board of Nursing, State Board of Medical Examiners, and the National Joint Practice Committee. A statement on the "Physician's Assistant" was prepared and forwarded to the Governor.

The plan for the 1975-76 year, will be to continue to encourage the establishment of local joint practice committees and to further clarify the role of nurse practitioner.

Filed (page Tr 120)

Supplement #2

MAJOR AND MINOR SURGERY (Reference Committee "F")

On May 13, representatives from the Ad Hoc Committee on Surgical Assistants, the New

Jersey Hospital Association, and the State Board of Medical Examiners met and agreed upon the following proposed revision to the Rule on Major and Minor Surgery:

RULE ON MAJOR SURGERY

(a) Major surgical procedures are those with a hazard to the life, health, and welfare of a patient.

(b) In accordance with the provisions of the Medical Practice Act, N.J.S.A. 45:9-1 et seq, any major surgical procedures with a hazard to life shall only be performed by a duly qualified surgeon with a duly qualified assisting physician, or a duly qualified surgical resident in a training program approved by the Educational Council of the American Medical Association or the American Osteopathic Association, except in matters of dire emergency. It shall be the responsibility of each medical staff to promulgate appropriate rules and regulations in this regard and the medical staff and the hospital board of trustees shall assure compliance by the individual physicians.

(c) A duly qualified surgeon, duly qualified assistant physician, and duly qualified resident shall be determined by the hospital credentials committee in conjunction with the chairman or chief of the appropriate department or division. It shall be the responsibility of each medical staff to promulgate appropriate rules and regulations in this regard and the medical staff and hospital board of trustees shall assure compliance by the individual physicians.

(d) Failure to comply with this rule may subject the physician to suspension or revocation of his license to practice medicine and surgery in this state, pursuant to N.J.S.A. 45:9-16 (g), and/or may subject any other person, association, corporation, or institution to the sanctions and remedies set forth in N.J.S.A. 45:9-22, N.J.S.A. 45:9-26, and N.J.S.A. 45:9-27.1.

Filed (page Tr 128)

Judicial Council

Albert F. Moriconi, M.D., Chairman, Trenton
(Reference Committee "A")

The Judicial Council has maintained its schedule of regular monthly meetings. From the official findings, the Council here presents a summary of its operations and those of county judicial committees for the period from June 22, 1975 through March 28, 1976.

BY JUDICIAL COMMITTEES

Complaints reported as disposed of	42
Alleging:	
Dissatisfaction concerning fees	20
Unprofessional conduct	7
Dissatisfaction concerning medical procedures	7
Dissatisfaction concerning professional ethics	8

BY THE JUDICIAL COUNCIL

Meetings held	6
Official communications acted upon	43
Appeal hearings requested	9
Appeal hearings granted	1
Formal opinions rendered	0

REGULATIONS

The Council would at this time like to point out to the chairmen of the judicial committees of the component societies a primary cause of appeals during the past several years.

The *Rules and Regulations* of the Judicial Council provide that when efforts for amicable settlements of complaints have failed a hearing must be held, to which all parties are invited, before the complaint can be disposed of at the county level.

All too frequently the Council receives requests for appeal hearings wherein the record reveals that after settlement efforts have failed, the judicial committees reached a final decision without the benefit of a hearing. The Council has been constrained in these instances to refer these cases back to the judicial committee with the directive to hold a hearing.

The Council urges that each county committee strive to improve its procedure in this regard. Therefore, the committees are again reminded to follow the directions contained and the procedural steps outlined in the *Rules and Regulations for the Processing of Grievances and Complaints*.

JUDICIAL WORKSHOP

A Judicial Workshop for chairmen, secretaries, executive secretaries, and members of the judicial committees of component societies was held again this year and the foregoing problems again were discussed in great detail.

There were 29 present at this meeting, representing 12 counties. Everyone in attendance agreed that the meeting was most enlightening and informational.

Only by means of a full understanding and observance of the "Regulations" can the judicial committees, together with the Judicial Council, succeed in functioning at the level of adequacy intended by MSNJ's House of Delegates.

Filed (page Tr 120)

Executive Director

Vincent A. Maressa, Trenton

(Reference Committee "A")

Each year the report of the Executive Director is submitted to the House, considered by Reference Committee "A", and then filed. This year will not, I assume, present a significant departure from that format. One of the obligations of our office is, however, to bring to your attention matters of particular import.

No institution, organization, or society can be all things to all men. The attitude of the medical profession in general, the House of Delegates, and the Board of Trustees on legislative matters, in particular, does, however, attempt to achieve just such a posture. The end result is that unrealistic goals have been established, cannot be achieved, and in the realization of the failure thereof, the Society finds itself beset with conflict and disagreement from within, for no truly useful purpose.

You cannot continue to take positions on 300-500 bills in a given Legislative Session and expect to have any influence on their outcome. If you don't anticipate having an effect on their processing — why take a position at all?

When one considers that a given Administration may develop only 50 legislative measures in a Session, how can The Medical Society of New Jersey expect to influence the course of several hundred?

During the recently completed two-year Session of the Legislature, the single most effective

Senator was responsible for the passage of twenty-five laws, the next most effective accounted for twelve, and the next most effective for eight. In each instance, while Administration support was not always 100 per cent present, there was no Administration opposition!

Clearly, the time has come for MSNJ to constrict its legislative aspirations within realistic parameters. An area that deserves initial concern is that of the licensure of ancillary professionals and/or the expansion of their permitted functions. The Society is often criticized in this type of activity as being "opposed to everything," "selfish," "interested in monopolizing the health-care field to preserve its own economic empire." The end result is a torrent of diatribe, invective, hostility, and frustration.

Perhaps you should consider a posture that the Legislature can license whomever and whatever it so desires. If the medical practitioner is, as we assume, the most diversified, well-educated, scientifically expert, technically competent, and professionally astute practitioner of the healing art, what do you have to fear in a free and openly competitive market? Sooner than many anticipate, the consumer will, I suspect, place his faith and allegiance with those practitioners truly deserving of it. The economic benefits will, per force, naturally follow.

Reasonable comment from responsible sources is appreciated and solicited.

Filed (page Tr 120)

Standing Committees

Annual Meeting

James E. D. Gardam, M.D., Chairman, Millville

(Reference Committee "H")

The 210th Annual Meeting of The Medical Society of New Jersey is being held for the second time in Cherry Hill and includes the Second Annual Governor's Conference. The latter session is a specialized scientific meeting which has been well attended and its continuance is recommended. The 210th meeting also includes the innovation of an open meeting with a report to the membership by AMA Delegates. Since there is no prior experience with this session, a recommendation for continuation will be deferred.

During the year, other sites for a meeting have been considered and evaluated by the Annual Meeting Committee. It appears that the Cherry Hill area facilities, service, and market leadership will continue to improve and provide a suitable and satisfactory location for future meetings.

Recommendations

1. That the 211th Annual Meeting (1977) be held in the Cherry Hill area.

Not Approved (page Tr 133)

Upon motion from the floor the House directed that the Committee on Annual Meeting, with the advice and consent of the Board of Trustees, be authorized to select the site of the 1977 Annual Meeting.

2. That the Governor's Conference be continued as a feature of the Annual Meeting.

Approved (page Tr 133)

Filed with notation (page Tr 133)

SCIENTIFIC PROGRAM

James E. D. Gardam, M.D., Chairman, Millville

At the 210th Annual Meeting, 49 member-speakers and 31 guest-speakers will present scientific papers at 17 Scientific Sessions. The 2nd Annual Governor's Conference on Primary and Secondary Prevention in Adult Medicine, co-sponsored by the Department of Preventive Medicine and Community Health of CMDNJ-

New Jersey Medical School, will be held on Saturday morning during the Convention. In addition, the Annual Spencer T. Snedecor Trauma Oration will be presented by the New Jersey Committee on Trauma; and the New Jersey Chapter, American College of Chest Physicians, will again sponsor the Annual Selman A. Waksman Lecture.

Through the Academy of Medicine of New Jersey, hour-for-hour credit for all of the 1976 Scientific Sessions and the Governor's Conference has been approved for Category I, AMA Physician's Recognition Award, Continuing Medical Education Program, MSNJ; and the three sessions being sponsored by MSNJ's Section of Family Practice have been approved for two hours each of Prescribed Credits by the American Academy of Family Physicians.

The excellence of the scientific programs bears out the opinion that co-sponsorship by the New Jersey Specialty Societies should be continued in future years.

Filed (page Tr 133)

SCIENTIFIC EXHIBITS

Francis X. Keeley, M.D., Chairman, Haddonfield

The Committee on Scientific Exhibits met in the Fall of 1975, and again in February 1976. The space for both Informational and Scientific Exhibits was severely limited this year. After a thorough discussion of alternative plans, the Committee felt the only reasonable course was to limit invitation to scientific exhibitors from New Jersey. We are certain that the quality of the exhibits will make up for the decrease in number. Once again an excellent program of medical films will be available at the Motion Picture Theatre, Saturday afternoon through Monday afternoon.

Filed (page Tr 133)

Credentials

Arthur Bernstein, M.D., Chairman, Maplewood
(Reference Committee "A")

The Committee on Credentials throughout the year reviewed and acted upon membership applications and their supporting credentials as submitted through the component societies.

The following statistical breakdown reflects the Committee's activities during the period March 1, 1975 to February 29, 1976.

	*Associate	Active	Grand Total
Received:			
*Interns	7		
*Residents	20		
Grand Total	27	841	868
	*Associate	Active	Grand Total
Reviewed and found:			
(a) Satisfactory			
*Interns	4		
*Residents	9		
Subtotal	13	754	767
(b) Unsatisfactory	0	0	0

Pending:

*Interns	3		
*Residents	11		
Subtotal	14	87	101
Grand Total	27	841	868

*Associate membership (non-licensed in New Jersey) designates Interns and Residents.

The Committee extends appreciation to the secretaries of component societies, and to those who assist them, for their cooperation in processing membership applications. It would be helpful especially to the Credentials Committee of MSNJ if those who process credentials in the component societies would call specific attention to any deficiencies or questionable data being submitted on the application form. This procedure will help to insure more accurate and speedy evaluation of credentials.

Filed (page Tr 120)

Honorary Membership

Charles H. Calvin, M.D., Chairman, Edison
(Reference Committee "H")

No nominations were submitted this year to the Committee. Consequently, no meetings were

held during this administrative year.

Filed (page Tr 133)

Finance and Budget

I. Edward Ornaf, M.D., Chairman, Cherry Hill

(Reference Committee "B")

A review of the expenses of the first ten months of the current administrative (fiscal) year and an estimation of the expenses for the final two months indicate that the individual budget accounts are sound.

THE JOURNAL AND ANNUAL MEETING EXPENSE

The (net) *Journal* Deficit is anticipated to be higher, even though this will be the fourth year that a per capita assessment designated for each member's *Journal* subscription rate will be applied. The dues allocation to the *Journal* will be \$5.00 per member for 1976 as it was for 1975 or one-half of the yearly subscription rate.

The anticipated increase in the net deficit can be attributed to several factors: (1) national advertising revenue has risen for the first time in years; however, it has not been sufficient to absorb the increased 1976 publishing cost estimated at 11.1 percent, (2) non-printing costs centering on personnel salaries, taxes, commissions, office expenses, and insurance can be held accountable for the remainder of the deficit increase. The experience in 1976 has been consistent for all state journals. It is anticipated by this time next year after the New York national advertising firm (United Media Associates) will have completed more than a year's activity, total national advertising revenue will be higher and a better report will be in the offing.

Your Committee recommended, with the concurrence of the Board of Trustees, that the 1977 assessment include a \$5 and \$2.50 per capita assessment designated for each member's *Journal* subscription rate, and Annual Meeting registration rate, that the full amount realized as of May 31, 1977 be applied in 1977, and that the Committee on Finance and Budget be called upon to review these allocations annually.

Your Committee was cognizant of the fact that the above action will not completely discharge the deficits incurred each year in these two accounts. Nevertheless, the net deficit in each ac-

count will be considerably less and will be charged to the unexpended balance of the fiscal budget or the balance of the General Fund (unappropriated).

PRESIDENT AND PRESIDENTIAL OFFICERS

Your Committee has approved, with the concurrence of the Board of Trustees, the inclusion of \$15,000 in the budget of the President and Presidential Officers. The foregoing represents a net increase of \$5,000 to cover the President of The Medical Society of New Jersey while holding this office. It is to reimburse the President for loss of his practice while serving the office of Presidency.

MEDICAL EDUCATION AND THE ACADEMY OF MEDICINE OF NEW JERSEY

Your Committee again has approved, with the concurrence of the Board of Trustees, the inclusion of \$25,000 in the budget of the Committee on Medical Education for 1976-77 for the Academy of Medicine of New Jersey for post-graduate educational programs and activities, with the continued proviso that the Committee on Medical Education, with the concurrence of the Board of Trustees, be empowered to expend up to this amount in the course of the administrative (fiscal) year on the basis of need reflected in the 1976-77 fiscal report to be submitted by the Academy of Medicine of New Jersey to the Committee on Finance and Budget.

EMERGENCY MEDICAL CARE AND THE INTER-AGENCY COMMISSION ON EMERGENCY MEDICAL CARE

Your Committee has approved, with the concurrence of the Board of Trustees, the inclusion of \$10,000 (for the second year) in the budget of the Committee on Emergency Medical Care for 1976-77 for the Inter-Agency Commission on Emergency Medical Care. The foregoing does not represent any increase to the 1976-77 budget.

FOUNDATION OF THE COLLEGE OF MEDICINE AND DENTISTRY OF NEW JERSEY

Your Committee has approved, with the concurrence of the Board of Trustees, the inclusion of \$10,000, establishing a new account for 1976-77, for the Foundation of the College of Medicine and Dentistry of New Jersey. The monies allocated for 1976-77, as well as for each subsequent fiscal year through 1980-81, will be budgeted to achieve a total contribution of \$50,000 over the next five (5) years.

NEW JERSEY FOUNDATION FOR HEALTH CARE EVALUATION

Your Committee has approved, with the concurrence of the Board of Trustees, the proposed 1976-77 budget prepared by the Finance Committee of the New Jersey Foundation for Health Care Evaluation. The budget totals \$85,947.

1977 ASSESSMENT

The computation of unappropriated General Fund balance at the close of the current fiscal year is estimated at \$242,406.04 — 21.2 percent above the \$200,000 sum approved, with the concurrence of the Board of Trustees, as the desired minimal surplus.

In accordance with Chapter X of the Bylaws, the dues year is January 1 to December 31, and the fiscal year is June 1 to May 31. The administrative year including the budget, which controls expenditures, is based on the fiscal year. It therefore becomes necessary to apportion the 1976 and 1977 per capita assessment to the 1976-77 fiscal year on the basis of 7/12 of the 1976 assessment for the new fiscal year soon to commence (June 1, 1976) and 5/12 of the 1977 assessment for the latter part of that fiscal year starting January 1, 1977.

The following is the Computation of the Cash Surplus and the Determination of the 1977 Assessment: (Unappropriated General Fund Balance)

Proposed budget for 1976-77	\$858,914.00
7/12 of 1976 assessment applicable to 1976-77 budget	<u>\$443,028.54</u>
Amount to be raised by 5/12 of 1977 assessment	<u>\$415,885.46</u>

$\$129.57 \times 7,704$ members paid =	\$998,207.28
× 5/12	\$415,919.70
Amount to be raised with surplus over \$200,000.00 applied to budget excess at 5/31/76, estimated	\$ 42,406.04
Amount needed to reduce the per capita assessment from \$129.57 to \$120.00	<u>\$ 30,685.46</u>
Remainder of surplus in excess of \$200,000.00	\$ 11,720.58
Add the required surplus	<u>\$200,000.00</u>
Estimated adjusted cash surplus at 5/31/76	<u>\$211,720.58</u>
$\$120.00 \times 7,704$ members paid =	\$924,480.00
× 5/12	\$385,200.000
plus the amount raised from surplus	<u>\$ 30,685.46</u>
Amount to be raised to meet 5/12 requirement	<u>\$415,885.46</u>
For each \$1,000 increase in the proposed budget add .312¢ to assessment.	
For each \$1,000 decrease in the proposed budget subtract .312¢ from assessment.	

1976-77 BUDGET

The proposed budget for 1976-77 totals \$858,914. It is the opinion of the Committee that the budget adequately should provide the necessary funds for the efficient operation of the Society's business during the coming year. It is not to be assumed that all sums budgeted necessarily will be utilized.

As requested by the House of Delegates, your Committee is listing explanatory footnotes on accounts which show a marked difference between current and proposed budgets.

Recommendations

(1) That the Budget for 1976-77 be adopted in the total sum of \$858,914.

Approved (page Tr 121)

(2) That the 1977 assessment be adopted at \$120 per capita, with no provision for a contribution to AMA-ERF. The dues assessment will cover a budget allocation, for the eighth consecutive year, to the Academy of Medicine of New Jersey which eliminates the need for a special assessment therefor. The dues assessment will also cover a budget allocation, for the third year, to the Inter-Agency Commission on Emergency Medical Care, and, for the first year, a budget allocation to the Foundation of the College of

Medicine and Dentistry of New Jersey. Of the \$120 per capita assessment, \$5 and \$2.50 be designated respectively for the member's *Journal* subscription and Annual Meeting registration; and that the full amounts realized as of May 31, 1977, be applied in 1977.

Approved (page Tr 121)

(3) That a special assessment be adopted at \$10 per capita, to serve as a grant to the New Jersey

Foundation for Health Care Evaluation; that this special per capita assessment be set in addition to and not as part of, the budgetary assessment; and that both be paid at the same time.

Approved (page Tr 121)

(4) That the 1977 assessment be set at \$20 per capita for affiliate and associate members as it was for 1976.

Approved (page Tr 121)

Filed (page Tr 121)

Account	Current Budget 1975-76	Footnotes	Proposed Budget 1976-77
A— 1—Executive Salaries	\$113,097.00	(1)	\$128,895.00
A— 2—General Staff Salaries	234,255.33	(1)	262,708.50
A— 3—Gen. Exec. Office Expenses	32,000.00	(2)	39,000.00
A— 4—Executive Travel	7,600.00		4,700.00
A— 5—House Maintenance	34,400.00	(3)	36,800.00
A— 6—Treasurer	9,900.00	(4)	11,800.00
A— 7—Finance & Budget	75.00		75.00
A— 8—Secretary	400.00	(5)	1,700.00
A— 9—Salary Taxes	20,034.67	(1)	21,200.50
A—10—Insurance	18,500.00	(6)	25,750.00
A—11—House Reserve	9,200.00	(7)	12,800.00
A—12—MSNJ Pension Plan	4,200.00	(8)	5,200.00
A—13—MSNJ Building Loan	12,800.00		12,240.00
A—14—AM-CAP Computer Program	24,000.00		23,500.00
C— 2—Legislation	7,000.00	(9)	10,000.00
C— 3—Public Health	5,400.00		3,600.00
C— 4—Public Relations	35,300.00	(10)	52,700.00
C— 5—Medical Services	750.00		750.00
C— 6—Mental Health	1,700.00		1,700.00
D— 1—President & Pres. Officers	17,800.00	(11)	21,700.00
D— 2—AMA Delegates	24,400.00		22,000.00
D— 3—Woman's Auxiliary	6,300.00	(12)	8,195.00
D— 4—Medical Education	30,500.00	(13)	40,800.00
D— 5—Conference Groups	500.00		500.00
D— 6—Membership Directory	20,000.00	(14)	26,000.00
D— 7—Emergency Medical Care	10,400.00	(15)	10,500.00
D— 8—Credentials	1,200.00		1,200.00
D— 9—Archives & History	1,000.00	(16)	—0—
D—11—Med. Def. & Insurance	700.00	(17)	900.00
D—12—Mem. Inq. & Complaint	1,000.00		1,000.00
E— 1—Board of Trustees	9,000.00	(18)	10,000.00
E— 2—Contingent	10,000.00	(19)	20,000.00
E— 3—Judicial Council	1,000.00		1,000.00
E— 4—Legal	13,000.00		13,000.00
E— 5—CMDNJ — Foundation	—0—	(20)	10,000.00
E— 6—Medical Student Loan Fund	6,000.00		6,000.00
E— 7—Authorized Reimbursement for Representatives to Meetings	5,000.00		5,000.00
E— 8—Physicians' Relief Fund	6,000.00		6,000.00
TOTALS	<u>\$734,412.00</u>		<u>\$858,914.00</u>

- (1) Increased due to increments granted to both executive and general personnel.
- (2) Increased to cover higher luncheon cost, rental cost on Xerox/Cheshire 730 Addressing System, and preventive maintenance agreements. This account also covers monthly bank loan payments on the purchase of telephone equipment.
- (3) Increased to cover higher property taxes and house maintenance costs.
- (4) Increased to cover higher expenses anticipated in accounting and auditing services.
- (5) Increased to cover the Secretary's expense in attending the AMA Annual and Clinical meetings.
- (6) Increased to cover higher expenses anticipated under the insurance programs for the staff and The Medical Society of New Jersey.
- (7) Increased to cover higher allocation for capital expenses and periodic large maintenance cost.
- (8) Increased to cover the anticipated expense associated with the completion of the revision of MSNJ Employees' Pension Plan as required under the Pension Act (Erisa) September, 1974.
- (9) Increased to cover higher expenses associated with MSNJ providing soft dollar, administrative assistance to JEMPAC.
- (10) Increased to cover higher expenses associated with the expanded Public Relations Program.
- (11) Increased to cover higher reimbursement allowance for the President of The Medical Society of New Jersey.
- (12) Increased to cover higher expenses anticipated by the Woman's Auxiliary.
- (13) Increased to cover anticipated higher administrative costs associated with the Continuing Medical Education Program of The Medical Society of New Jersey. This account provides for the Medical Education Committee, with the concurrence of the Board of Trustees, to expend up to \$25,000 in the course of the administrative year (1976-77) to the Academy of Medicine of New Jersey for postgraduate educational programs and activities, on the basis of need reflected in the fiscal report to be submitted by the Academy to the Committee on Finance and Budget.
- (14) Increased to cover higher anticipated expenses associated with the publication of the 1976-77 edition of the *Membership Directory*.
- (15) Increased to cover higher expenses. Also provides the Inter-Agency Commission on Emergency Medical Care with an allocation for 1976-77 of \$10,000.
- (16) This account is deactivated because its function has been accomplished.
- (17) Increased to cover higher expenses.
- (18) Increased to cover higher anticipated expenses associated with the Board's annual meeting functions.
- (19) Increased to bring this account to a realistic level needed to cover contingencies not anticipated for 1976-77.
- (20) Establishes a new account covering a yearly allocation of \$10,000 for the Foundation of the College of Medicine and Dentistry of New Jersey for 1976-77 and for each subsequent fiscal year through 1980-81 until a total contribution of \$50,000 is achieved.

STATE SOCIETIES DUES FOR THE YEAR 1976

Below are the fifty-one State Societies in the order from the highest dues assessment down to the lowest:

1. Wisconsin	\$300	26. Indiana	\$150
2. District of Columbia	275	27. Pennsylvania	150
3. Wyoming	275	28. Washington	147
4. Nevada	260	29. North Carolina	145
5. Idaho	250	30. New Mexico	135
6. Alaska	250	31. Illinois	130
7. Georgia	250	32. Texas	130
8. Kentucky	225	33. North Dakota	125
9. Minnesota	225	34. Alabama	125
10. Maine	225	35. Ohio	125
11. Hawaii	215	36. Arkansas	125
12. Montana	200	37. Kansas	125
13. Iowa	200	38. Mississippi	125
14. South Carolina	180	39. Vermont	125
15. South Dakota	175	40. Florida	125
16. Colorado	170	1977* 41. New Hampshire	120
17. Arizona	170	1976* 42. New Jersey	110
18. Utah	165	43. Massachusetts	110
19. Delaware	165	44. New York	100
20. California	165	45. Nebraska	100
21. Maryland	160	46. Rhode Island	100
22. Oregon	155	47. Louisiana	100
23. Michigan	155	48. Missouri	100
24. West Virginia	150	49. Virginia	85
25. Oklahoma	150	50. Connecticut	85
51. Tennessee			80

Medical Defense and Insurance

Paul J. Kreutz, M.D., Chairman, Elizabeth

(Reference Committee "C")

In 1975, the major changes affecting our plans administered by E. & W. Blanksteen were as follows:

1. The maximum monthly benefit issued under the Accident and Health Programs was increased to \$4,600 a month with up to \$2,000 available in the basic program and up to \$3,600 available in the long-term program, both subject to an overall \$4,600 limit.

2. The long-term program is now "Your Occupation" for the full benefit-paying period, which is lifetime for accident and up to age 65 and beyond for illness. This extension is coupled with a special "Return-to-Work" feature which is operative when the disability has lasted longer than five years.

3. The Aetna Life & Casualty Company, the parent company of the Automobile Insurance Company of Hartford, announced that it could not continue the EPIC automobile and homeowners programs beyond June 30, 1976 due to the crises in the casualty insurance industry and the tremendous losses all carriers are experiencing. Every policyholder will be offered a guaranteed issuance of a conversion policy in the Individual Department of the company, so that no participant will be left without insurance coverage. In many instances, the conversion premium will be only modestly higher than the group premium. We are looking for a replacement group casualty carrier, but none is presently available.

ACCIDENT AND HEALTH INSURANCE

The Society's Accident and Health insurance programs are administered by the E. & W. Blanksteen Agency, Inc., who have just completed their 45th year of service to our members. This comprehensive disability income program now affords a monthly benefit up to \$4,600 during total disability due to injury or sickness. The program consists of two parts: The Basic-Extended Plan and the Long Term Plan. The plans differ primarily in the length of time benefits are payable. For an accident disability, the Basic Plan pays up to five years; the Basic-Extended plan up to lifetime; and the Long Term plan up to lifetime. For a sickness disability, the Basic plan pays up to two years; the Basic-Extended plan up to seven years; and the Long Term plan up to age 65 and beyond. Both the Basic-Extended Plan and the Long Term plan are underwritten by the Nationwide Mutual Insurance Company. Members may carry up to \$4,600 of which up to \$2,000 may be in the Basic

Plan and up to \$3,600 a month in the Long Term plan. Up to three policies are issuable to any member for maximum flexibility. The Company will re-arrange policies and existing coverage to accommodate changing needs within the three-policy limit.

BASIC-EXTENDED PLAN

The Basic Disability Plan provides as much as \$2,000 monthly benefit with the Nationwide Mutual Insurance Company. Benefits are payable from the first day of accident total disability for as long as five years and the eighth day of sickness total disability for as long as two years. Waiting periods of 30 or 60 days are available to provide reduced premiums for those whose circumstances make desirable a plan where benefits could begin on a later date than 1st day accident and 8th day sickness. The plan also pays, at half the monthly rate, accident partial disability benefits for as long as six months. Also included in the plan are accidental death and dismemberment benefits. By adding the Extended plan, accident total disability benefits may be extended to lifetime and sickness benefits extended for an additional five years, for a total of seven years. There are 4,850 basic policies covering our members with some members having two basic policies. It is the Administrator's practice to combine two basic policies into one whenever members revise or increase their insurance programs so as to simplify their record-keeping.

LONG-TERM PROFESSIONAL INCOME PROTECTION PLAN

Members may now carry up to \$3,600 under this plan. Benefits are payable for lifetime for accident total disability and to age 65 and beyond for sickness total disability. One of the chief purposes of this plan is to provide both accident and sickness disability benefits to the age where other financial arrangements begin to fall into place; such as annuities, life insurance settlement options, and social security. The plan also af-

fords six months of accident partial disability at half the monthly benefit rate. Benefits may begin from the 31st, 61st, 91st or 181st day of disability, with appropriate reductions in premium. 1,760 members currently participate in this program which began in 1965.

It is possible for a member to have the various disability plans in almost any combination of monthly benefit and plan to fit personal requirements. The ideal goal for most doctors is to insure about two-thirds of monthly gross income. More monthly benefit than this is unnecessary inasmuch as all benefits are tax free for Federal Income Tax purposes. Members who apply for the Basic Plan within their new member periods are issued coverage, within certain limits, without regard to medical history.

All of our accident and health policies have the guaranteed Conversion Provision Rider. Briefly, this rider provides that if Nationwide were unilaterally to terminate any of its accident and health insurance programs for members of the Society the Company is committed to issue a guaranteed renewable policy for the same benefits as are provided in the doctor's original policy.

MAJOR EXPENSE PLAN

Our Major Expense Plan was improved (effective March 1, 1975) by the addition of the "Quarter Million" Dollar Rider extending coverage beyond the \$25,000 limit of the base policy to \$250,000 for members below Medicare age.

Until \$25,000 has been paid on any claim, the room and board rate is \$100 daily for intensive care and \$50 for all other accommodations. The private duty nursing benefit takes into account as covered expense \$24 for each eight-hour shift. (RN or LPN in the hospital; RN at home.) Also, certain services and supplies both in and out of hospital are covered. After a \$750 deductible for each benefit period, 80 percent of Covered Expenses is paid up to a maximum of \$25,000. There is *no* coordination-of-benefits provision for those below Medicare age! After the base policy has paid \$25,000 and the claim continues, the "Quarter Million" Dollar Rider takes over with expanded coverage (since primary hospital

plans may be exhausted by this time). Hospital room and board coverage is now full semi-private cost (up to double for intensive or coronary care units) and covered nursing charges are paid-in-full. The services and supplies covered by the base plan continue to be covered by the Rider; 100 percent of covered expense is reimbursed and benefits are *not* reduced because of other non-government coverage.

Premiums were increased effective March 1st, 1976 in view of a rising trend of claim payments to members utilizing the benefits of the plan.

The program now covers 2,519 members with many members including coverage for their wives and children. New members of the Society may obtain coverage under the Major Expense Plan without regard to medical history provided they apply within their allotted two-month new-member period. E. & W. Blanksteen Agency, Inc., administers this plan.

HOSPITAL-MONEY PLAN

Our Hospital-Money Policy, administered by E. & W. Blanksteen Agency, Inc., provides \$20, \$30, \$40, \$50 or \$60 a day for each day of hospital confinement up to a maximum of 365 days for any one confinement. It can cover member, spouse, and dependent children. New members are able to obtain the \$20 a day program non-selectively as part of their new-member privilege. Three hundred five members participate in this program.

OVERHEAD EXPENSE PROGRAM

Many of our members find that their overhead expenses have become quite high, with employees' salaries, rentals, and other fixed expenses pertaining to their practice. Our Professional Overhead Expense Program is underwritten by the National Casualty Company and administered by the E. & W. Blanksteen Agency, Inc. It provides up to \$2,500 monthly benefit beginning with the 31st day of total disability and lasting as long as two full years. Currently, 286 members are covered under the plan. In accordance with IRS regulations, the premiums under this program are considered business expense *and are tax deductible*.

LIFE INSURANCE — NATIONWIDE LIFE
INSURANCE COMPANY AND BANKERS LIFE
COMPANY OF DES MOINES, IOWA

The maximum coverage under our Life Plan is \$250,000 with the \$100,000 maximum coverage Bankers Life Plan available in addition to the \$150,000 program of the Nationwide Life Insurance Company that has been in effect for many years.

Our original Nationwide Life Insurance Program includes not only the member but also his spouse and dependent children (between the ages of 15 and 21 — up to age 26 if a college student), as well as employees. An important feature of this expansion is that each person will have his own Five Year Renewable and Convertible Term Policy and it is not necessary for the member to take out insurance for himself in order to provide coverage for a member of his family or an employee. This added feature enables the life insurance program to serve many more needs of our members especially those who wish to provide benefit programs for their employees. The administrators are E. & W. Blanksteen Agency, Inc.

The Nationwide life program provides each insured person with a Five-Year Renewable and Convertible Term Policy with a guaranteed conversion on a non-medical basis to permanent life insurance at any time. The program now provides up to \$150,000 of coverage for members and up to \$50,000 of coverage for spouse, dependent children, and employees. All coverage is issued in the form of convenient units of \$10,000 with Waiver of Premium and Double Indemnity for accidental death included without premium charge. Since inception of the program, there have been 295 death claims, resulting in a total payment of \$3,219,400.

As a result of the large volume of insurance and strong participation of our members in this program we are able to have non-cancellable term life insurance at a very low cost. At the present time, over 1,800 of our members participate in the program with approximately \$30,185,000 of insurance currently in force. This plan is also available to spouses, children, and employees and 103 of them participate in this program.

The additional \$100,000 coverage through the Bankers Life Company is available to members whether or not they carry insurance under the original program. This will make possible larger amounts of insurance without the necessity of another physical examination and give our members even greater flexibility in establishing their insurance program. The net cost and structure of the Bankers Life Program is quite similar to that of the Nationwide Life Insurance Company described above.

Of our members 148 have applied for and were issued \$5,632,000 of insurance protection under this new plan, as of January 1, 1976.

SIX POINT, HIGH-LIMIT ACCIDENT INSURANCE

Our Six Point, High-Limit Accident Insurance Plan with the Nationwide Mutual Insurance Company, administered by E. & W. Blanksteen Agency, Inc., provides up to \$200,000 for accidental death benefit with dismemberment benefit, loss of sight, exposure, disappearance and even a total disability feature, at less than the usual cost of the accidental death benefit.

Special spouse coverage is available under this policy at very low cost. Of our members 755 participate in this program.

PROFESSIONAL CORPORATIONS

E. & W. Blanksteen Agency, Inc., our administrator for the Basic-Extended, Long Term Professional Income Protection Plan, Major Expense Plan, Hospital-Money Plan, Six-Point High Limit Accident Insurance Plan, the Automobile Insurance Plan, Overhead Expense Plan and Life Insurance Plan, has advised that all the programs are adaptable for use in professional corporations with necessary assignment forms available upon request.

Recommendation

That the E. & W. Blanksteen Agency, Inc., be continued as the Official Broker for MSNJ's Accident and Health Insurance, Major Expense Insurance, Hospital-Money Plan, Life Insurance, Six Point High-Limit Accident Insurance, and Professional Overhead Expense Plan.

Approved (page Tr 123)

PROFESSIONAL LIABILITY

Most physicians are well aware of the national publicity given by the news media during the past year to the subject of professional liability. Unfortunately, many references portraying claims and suits seemed to emphasize the catastrophic medical injury so infrequently suffered by patients; or referred to those few situations where the acts resulting in injury have reflected extensive negligence and not quality medical care. The fact that physicians are not legally liable in the great majority of claims or suits, did not appear to be given equal emphasis.

Details were also provided on the extensive activities engaged in by physicians in attempting to resolve some of the problems related to availability of insurance. For instance, in a number of states as insurance companies withdrew from the market, or signified such intention, the potential lack of viable insurance protection became apparent. In some areas this type of problem was solved through development of physician-controlled insurance companies, or by involvement of state governments in creating active or standby joint underwriting associations and similar facilities.

In some western states, measures taken by physicians, including strike, brought little or no rate relief, subsequently requiring the payment of extremely high insurance premiums to continue in practice. This has resulted in a few isolated cases of physicians no longer purchasing insurance protection — “going bare,” so to speak, and accepting the risks attendant with such action.

The news media also covered those actions taken by physicians or medical societies directed toward obtaining legislative relief through attempts to revise the statutes controlling the extent to which they are deemed liable in the event of a professional liability claim, or the maximum amounts to which they are exposed. In some states, substantial relief was obtained via provisions establishing a maximum amount payable by health care producers on professional liability actions. These provisions sometimes included payment of supplementary amounts from assessments against health care providers over and above insurance premiums. This action has

helped maintain availability of insurance. Reportedly, in the past fifteen months, corrective legislation has been enacted in thirty or more states to relieve some of the long-range responsibilities of physicians or to provide for availability of insurance.

Physicians in New Jersey have not been as affected to date in comparison to many other areas. However, we are aware that certain corrective measures are also desirable here, in an effort to prevent our members from being similarly affected at a later date. Also, we have had some unique problems centralized in certain regulatory agencies, which complicated continuation of our program. Assisting the development of corrective measures and in maintaining or implementing desirable modifications in the present program, has required much of the Committee's attention.

The cooperation and participation by representatives from a number of specialty societies is acknowledged and appreciated.

In mid-1974, following announcement by the Commercial Union Insurance Company that they would not renew “umbrella” policies as of July 1, 1975, an intensive search was conducted for a new carrier. Initially arrangements were made with a “non-admitted” insurance company to assume this phase of our program. A commitment to provide “umbrella” coverage was also received from Crum & Forster, a highly qualified and financially stable insurance company, domiciled and licensed in New Jersey. Their proposal was contingent upon obtaining approval of rules and rates which had been filed with the New Jersey Department of Insurance in late 1974. Following a number of meetings with the Insurance Department and commencement of other actions, a revised filing was approved which permitted writing this coverage as of the date our previous carrier's policies expired. We have been advised that Crum & Forster will continue to provide this protection in 1976. No increase in rates is anticipated except for a minimal change applicable to the non-professional coverage afforded by the policy.

Regarding professional liability insurance, at the 1975 convention, the House of Delegates ap-

proved a rate increase of 23.7 percent and approved a 24.3 percent revision in higher limits tables. Due to the extensive interest in rates for professional liability insurance, a public hearing was held under direction of the New Jersey Department of Insurance. Following this hearing and a number of other meetings, an overall rate increase of 49.5 percent was approved as of September 23, 1975. The actual percent of increase *varied among the different classes of practice due to a revised approach requested by the Commissioner of Insurance*. Under this approach, a fixed dollar amount is established for certain expense items, which does not vary by specialty, prior to the application of other elements in the rating formula.

The following is a brief resume of other action taken by the Committee during the past year:

1. Explored payment of premiums on periodic bases. While Federal Insurance Company, because of its corporate charter, could not comply with this request, new financing arrangements at lower interest rates were developed by our broker.

2. Revised rules to provide that professional liability coverage under our program would be available only to member physicians who practice 75 percent or more of their time in New Jersey.

3. Revised rules to provide that employed physicians and nurse anesthetists be required to carry underlying professional liability limits of \$500,000/\$1,500,000 using a desirable policy form and with an acceptable company.

4. Agreed to extend availability of coverage to interns and residents and other hospital-based physicians, who are, or become members of the Medical Society, in view of inability of hospital insurance carriers to provide this protection.

5. Provided for development of information relative to any attorney who commenced unwarranted professional liability suits so that action could be implemented to eliminate this undesirable aspect of the professional liability program.

6. Agreed to provide for notification of individual specialty societies when physicians in their specialty —

(a) Wish to contest a decision by a county Medical Review and Advisory Committee that a claim or suit is non-defensible.

(b) Request that the insurance carrier settle a claim or suit which a county Medical Review Committee has determined is defensible.

7. Agreed to a "trial program" involving use of arbitration for an HMO being established in the Atlantic City-Cape May area.

8. Agreed to employ expert analysts as conditions required, for specific tasks at hand regarding all of the Society's programs.

9. Arranged for providing of loss prevention information in cooperation with the Academy of Medicine, as a part of the program for continuing medical education. The first step involved a program held May 5, 1976, at the Rutgers Medical School campus on the subject, "Malpractice Litigation — The Physician's Growing Dilemma."

10. Provided substantial material to Senator Greenberg's committee for its evaluation regarding the need for revisions in statutes relative to professional liability.

As previously reported, one major element which could have profoundly affected our professional liability program was the introduction of Assembly Bill A-1552. This bill proposed creation of a "professional liability insurance facility," under control of the Department of Insurance. Initially submitted in early 1975, the issues surrounding this bill were widely debated in and outside of the legislature during the entire year. The Committee felt this bill should be resisted principally because of the effect it could have on our present program plus the fact no problem existed regarding availability of insurance.

While availability of insurance has not presented a problem for our members, other segments of the health care industry have not been as successful in maintaining professional liability insurance markets. In 1975, the Argonaut Insurance Company withdrew from the program sponsored by the New Jersey Hospital Association. Other insurance companies covering hospitals also expressed some concern about the problems connected with professional liability. One company attempted to limit its liability through introduction of a "claims made" policy form. To assist in solving the hospitals' problem, a reciprocal insurance company, with limited financing, was organized under sponsorship of the Hospital Association, so as to provide *some* coverage for its members.

As a result of these developments, sufficient impetus was created to enable Bill A-1552 to pass the legislature in early January 1976, following substantial revisions in the original proposal. The Governor signed the bill on January 30, 1976, and shortly thereafter a professional

liability insurance facility was created which will afford coverage for hospitals in our state who could not obtain, or who shortly would be unable to obtain *adequate* insurance coverage. This action does not *automatically* provide for application of the "insurance facility" to physicians. Therefore, barring unforeseen circumstances, the Committee anticipates continuation of the professional liability program which has served our members so well during the past 16 years.

While amendments in present statutes and case law may be forthcoming, dependent upon the success of the Medical Society's efforts in the legislative arena, many of the conditions which have contributed to a need for previous rate increases continue to affect us. One of these factors is the continued inflation in the value of claim settlements — reportedly in excess of 15 percent annually. This factor must be contemplated in developing premiums collected today for settlements to be effected in the future.

Of equal or greater importance is the continued increase in the numbers of claims and suits that are being made which affects *all* of the companies that have provided or now provide professional liability insurance for the program. Naturally, most of these involve our present insurance company. For your information we are including a listing of claims and suits, separately by county and class of practice, submitted to Employer's of Wausau since 1968 and to Chubb & Son since 1971. The information relative to "suits" is of greatest importance in analyzing current trends. While it is true that the data for Chubb & Son encompass a larger number of insured physicians, a recent study of *comparable data* reveals they are receiving 1 suit for every 13 insured physicians versus 1 suit for every 17 insured physicians for Employer's of Wausau.

As of this time, the Committee is unable to provide detailed information relative to the premium which will be requested for the professional liability coverage for the 1976-1977 policies. A supplementary report will be submitted following discussions with the insurance company relative to the rates necessary to support the program along with an in-depth analysis of statistical material and other information available to the Society.

Recommendation

That the Joseph A. Britton Agency be continued as MSNJ's Official Broker for its professional liability program.

Approved (page Tr 123)

STATEWIDE BLUE CROSS/BLUE SHIELD PROGRAM

Since the last Annual Report, the Ocean County Medical Society has joined the Blue Cross-Blue Shield Program, increasing the participating county medical societies to 16.

The additional enrollments during the past year have brought the group total to almost 5,000. About 200 employees are covered under the program.

On July 1, 1975, a third surgical schedule was adopted. The new schedule was known as the "UCR (Prevailing Fee)" schedule. In practice, it pays 100 percent of the physician's charges for about 90 percent of the claims submitted. Blue Shield determines the Usual, Customary, and Reasonable fee (which is the benefit paid) for each surgical procedure by specialty and geographical location. On occasion, an amount in excess of the fee is paid in situations where the unusual complexity of the treatment or procedure required warrants a higher payment.

There was a rate increase on July 1, 1975, for covered individuals under age 65. The average increase was about 17 percent. However, for those over age 65, the premium was reduced by an average of 19 percent.

Our premium rates are based on the claims experience for our program.

Other groups, including "Community Plans" (small groups and individual policies) have been receiving significantly higher rate increases. By comparison our rate increase was considered to be relatively modest, which continues to make the program attractive to our members.

The program is administered by Donald F. Smith and Associates.

Recommendation

Cross-Blue Shield Program.

That Donald F. Smith and Associates be continued as MSNJ's Official Broker for its Blue

Approved (page Tr 123)

Filed (page Tr 123)

NUMBER OF CLAIM FILES ERCTED AND SUITS COMMENCED, BY COUNTY, AS REPORTED TO EMPLOYERS OF WAUSAU AND CHUBB & SON

	Claims		Suits	
	Employers 1968 to 1/1/76	Chubb 1971 to 1/1/76	Employers 1968 to 1/1/76	Chubb 1971 to 1/1/76
Atlantic	19	46	11	21
Bergen	235	240	86	158
Burlington	55	56	22	33
Camden	84	110	39	67
Cape May	2	8	1	7
Cumberland	32	26	18	21
Essex	418	379	177	268
Gloucester	17	34	3	28
Hudson	144	107	65	80
Hunterdon	9	18	3	14
Mercer	83	59	33	37
Middlesex	159	147	72	110
Monmouth	113	91	49	49
Morris	142	107	46	76
Ocean	62	98	25	75
Passaic	158	170	75	123
Salem	1	2	—	2
Somerset	42	35	18	26
Sussex	14	25	7	20
Union	269	204	100	133
Warren	9	14	7	8
Totals	2067	1976	857	1356

NUMBER OF CLAIM FILES AND SUITS COMMENCED BY CLASS OF PRACTICE, AS REPORTED TO EMPLOYERS OF WAUSAU AND CHUBB & SON

	Claims		Suits	
	Employers 1968 to 1/1/76	Chubb 1971 to 1/1/76	Employers 1968 to 1/1/76	Chubb 1971 to 1/1/76
G. P. Surgery	142	124	62	88
Emergency Room	—	3	—	2
Internal Med.	123	139	52	97
Cardiology	18	31	10	26
Gastroenterology	6	17	1	10
Allergy	6	4	3	1
Dermatology	22	19	9	9
Pediatrics	67	49	19	29
Pathology/Hematology	21	17	2	10
Neurology	13	13	8	7
Psychiatry	27	12	11	5
Industrial Med.	3	3	1	2
Prev. Med. & Pub. Hlth.	3	2	2	—
Rehab. — Physiatry	5	5	2	3
G.P. Minor Surg.	113	92	40	69
G.P. Major Surg.	83	56	42	37
Radiology	104	98	30	65
Ophthalmology	48	41	19	29
Otolaryngology	64	66	28	40
General Surgery	243	262	115	195
Ob-Gyn	263	293	109	207
Anesthesiology	180	150	36	78
Acupuncture	—	1	—	1

Orthopedics	307	254	167	186
Urology	53	46	25	36
Neurosurgery	69	69	35	54
Plastic Surg.	23	43	13	31
Thoracic Surg.	20	19	6	9
Proctology	5	6	1	5
Cardio-Vascular Surgery	13	15	5	13
Other Practice — N.O.C.	2	1	—	1
Retired	—	1	—	1
Employees	8	2	1	2
Emp. Phy/Nurse Anes.	—	4	—	1
Part./Corp.	13	13	3	6
Premises	—	6	—	1
Total	2067	1976	857	1356

Supplemental #1

Resolution #23 (1975 Annual Meeting) calling for a self-insurance study was adopted, as amended, and referred to the Committee on Medical Defense and Insurance. The Committee, in turn, requested that the Executive Director research the matter and submit a report thereon for appropriate action.

The following is the report submitted by Mr. Maressa which was reviewed by the Committee on Medical Defense and Insurance at its April 14, 1976 meeting and unanimously accepted for inclusion in the Annual Report.

GENERAL DISCUSSION

There are four possible approaches which bear the scrutiny of the Society and which, if necessary, could be implemented. Whether or not any or all are feasible, and/or desirable, is a matter which will be discussed in depth later on in this report. The following forms of self-insurance were reviewed:

1. Forming a captive stock company.
2. Forming a reciprocal exchange — Under this approach each "subscriber" executes an agreement empowering the common agent to assume on his behalf an underwriting liability on policies issued by the exchange covering the risks of other "subscribers." He assumes no liability as an underwriter on policies covering his own risk. The "subscriber's" liability is several and not joint and is limited by the terms of the agreement. Customarily, the agent is compensated by

payment of a percentage of premium income, out of which operating expenses are paid or by some other method.

3. A mutual insurance company — a non-profit corporation organized to write insurance for its owners. Because of its very nature it eliminates the need for a profit margin on the risk it retains. Mutuals may be organized either on an assessable form or on a non-assessable form and hence retain flexibility in the initial funding development.

4. A trust which does not fall under state insurance regulations.

The first three approaches all require a reinsurance format. The fourth approach (trust) does not involve reinsurance and, since it does not utilize the formal structure of an insurance company, would not be adaptable to that concept by a respectable reinsurance company.

REINSURANCE

As indicated above, the first three approaches demand reinsurance. The issue to be resolved is whether it is available presently at a reasonable cost.

Currently, there is no available market in the commercial carrier class in the United States. The only potential source, therefore, of reinsurance from a U.S. source is the newly formed AMA company. That company, however, is not in a position to reinsure a program of the magnitude of MSNJ's nor, according to AMA staff, will it secure such status in the foreseeable

future. Further, the AMA company is not at this time capitalized to the extent that it could feasibly reinsure any program.

Protracted discussions with the AMA staff and their consultants led to the conclusion that The Medical Society of New Jersey program is the soundest and most stable in the country. Their recommendation was, in fact, that while we should be prepared to self-insure, they would advise against such an action unless the current carrier were to depart drastically from its present position.

While there is a semblance of reinsurance available through two European sources, the costs thereof are considered prohibitive in comparison to even the high premiums prevailing in 1976. Further, the foreign companies have effectuated underwriting rules which are not compatible with MSNJ philosophy.

TRUST CONCEPT

This theory in terms of self-insurance is probably the most attractive of all. It is based on a cash flow principle and hence minimizes the current difficulties being presented by the reserving practices of casualty carriers. In order to be developed fully, however, there would have to be reasonable assurances that almost all members of this Society would be willing to commit themselves to a binding and long-term association. I have not observed any willingness of the medical profession to such a commitment, nor do I believe it feasible that absent a major catastrophe the tenor of physician opinion would change. Additionally, if this concept were employed it would virtually destroy the commercial insurance market and, consequently, render all physicians unwilling captives of MSNJ. Obviously, such a situation would produce an endless torrent of diatribe, invective, and litigation — both from within and without the Society.

CONCLUSION

It is evident, therefore, that based upon the foregoing, self-insurance of professional liability in New Jersey is presently neither desirable nor feasible.

Supplemental #2

Representatives from the Committee on Medical Defense and Insurance, Joint Ad Hoc Committee on Professional Liability, Executive Committee, Board of Trustees, and Administrative Office met with the Britton Agency and Chubb officials on March 24. Several hours were used to review actual statistics for New Jersey experience which actuarially indicated the need for an overall increase of 109 percent in premium costs. However, after consideration of favorable influences, the figure of 75 percent was proposed for the probable increase.

The Britton Agency had several meetings with Chubb officials with a 65 percent final increase on individual coverages, based on Chubb's statistics to be proposed for new and renewal policies in 1976. This lower percentage was accomplished by applying several factors and especially reducing the commission and expense portions of the premium dollar. The commission factor of 3.5 percent was reduced to 1.75 percent, the factor for company-related expenses performed by the broker was reduced from 1 to .75 percent, and the factor for the company's direct expenses was reduced from 2.5 to 2 percent.

The proposed premium dollar includes the above commission and expense factor of 4.5 percent plus 2.5 percent for New Jersey taxes and 5 percent for profit, which has not accrued for this line of insurance for many years. This permits 88 percent available for losses and legal expenses.

The proposed increase is lower in many instances when compared to proposed actions in other states and our overall costs compare favorably with most other states. We believed that if the increase is not accepted by MSNJ, Chubb might consider withdrawing from our program whereby the provisions of the facility under A-1552 probably would be applied. We doubt that any program administered under state control could operate with less than 20 percent to 25 percent for all costs and expenses as compared to our 12 percent.

Our program is recognized nationally and especially by the AMA as not only the best but the

only acceptable program in a problem state. It is being copied more and more where it can be used. The program is responsible for our rates being as low as they are and still permit an insurance company voluntarily to underwrite it. Assembly bill 1552 has no provision to continue the program or permit MSNJ to exercise any voice or control. This bill also could be the first step toward full state control and a state insurance company with no benefits for our members.

The Committee on Medical Defense and Insurance met on April 14 and recommended changes in classifications and rules. It appeared that the major problem would be an equitable distribution of the cost increase which would be acceptable to most of our members. The Committee reviewed fifteen possible plans of distribution with one selected to be further modified and referred to the Joint Ad Hoc Committee on Professional Liability.

The Joint Ad Hoc Committee on Professional Liability met on April 21 with representatives from the Committee on Medical Defense and Insurance and several specialty groups. It approved the changes recommended by the Committee on Medical Defense and Insurance. It further reviewed the distribution plans, plus seven new ones, with one selected to be referred to the Board of Trustees.

The Board of Trustees met on April 25 and reviewed the plans for distribution plus three new ones. The Board unanimously approved a plan which appeared to be most acceptable to the members as well as representatives of specialty groups.

The changes in classifications and rules as well as the percentage of increase and method of distribution are subject to approval of the Department of Insurance. The important changes which we feel are proper under our program and experience are as follows:

1. Preventive Medicine and Rehabilitation moved from Class 6 to Class 0, which is less expensive.
2. Neurology moved from Class 1 to Class 6, which is less expensive.

3. Charge for neurological procedures changed from 100 percent of Class 1, to 100 percent of Class 6, which is less expensive.
4. Charges for nurse anesthetists to be reduced considerably whether insuring directly or for vicarious liability when insured by another company.
5. The surcharge program to provide for maximum surcharge of \$10,000 for four or more chargeable claims. A chargeable claim to be one in which there is deviation from accepted medical standards and not one which necessarily is to be settled for legal or political reasons. There are other favorable procedural changes.

For years, we have applied the principle that premium charges and increases should parallel the loss experiences for our various specialties. We now realize that this principle should be changed unless we want to lose some of our specialists and preclude new ones from entering our state. As in automobile or other forms of casualty insurance, the insured with no losses has been required to assume more and more of the insuring expense for those unfortunate enough to have losses above the average, sometimes because of factors beyond their control. Our new principle, which we hope will be accepted by the New Jersey Department of Insurance, recognizes that all specialties will not produce the same losses and a ratio was selected which makes the better ones pay more so we can continue to insure the others. The new costs reflected substantial increases for some but the costs for all did not seem to be unreasonable when considering all circumstances.

The rates filed with the Insurance Department for limits of \$750,000 to \$2,250,000 are:

<i>Class</i>	<i>Current</i>	<i>Proposed</i>
7	\$ 579	\$ 889
0	787	1,287
6	909	1,554
1	1,473	2,878
2	1,849	2,878
3	3,159	5,532
4	6,218	10,838
5-Ortho	11,463	13,492
5-NS	17,708	16,143

Filed (page Tr 123)

Medical Education

Arthur Bernstein, M.D., Chairman, Maplewood

(Reference Committee "D")

The activities of the Committee on Medical Education in the past year have dealt primarily with implementing the CME Program, particularly the many problems arising from the approaching deadline of the first three-year period. The Committee has worked diligently to establish a program of continuing medical education throughout the State that is beneficial and meaningful to both the hospitals involved and the individual physicians.

A total of 70 accreditation surveys have been completed and the accredited hospitals to date are as follows:

Alexian Brothers	Millville
Atlantic City	Monmouth
Barnert Memorial	Morristown Memorial
Bayonne	Mountainside
Bridgeton	Muhlenberg
Burlington County Memorial	Newark Beth Israel
Carrier Clinic	Newcomb
Chilton Memorial	Overlook
Christ	Pascack Valley
Clara Maass Memorial	Perth Amboy General
Columbus	Point Pleasant
Cooper	Riverside
Deborah Heart and Lung	Roosevelt
Dover General	Somerset
East Orange General	St. Clare's
Elizabeth General	St. Elizabeth
Englewood	St. Francis (JC)
Freehold Area	St. Francis (Tren)
Hackensack	St. James
Helene Fuld	St. Joseph's
Holy Name	St. Michael's
Orange	St. Peter's General
Jersey City	St. Vincent's
Jersey Shore	Underwood Memorial
J. F. Kennedy	United of Newark
Martland	Valley
Princeton	VA (East Orange)
Mercer	Warren
Middlesex General	West Jersey

The remainder of the hospitals to be surveyed should be completed by the time of the Annual Meeting. The Committee is currently receiving requests for resurveys, due to the varying periods of accreditation granted to the hospitals. Resurveys are required in order for the hospitals to continue offering accredited programs for Category I. The Committee gratefully acknowledges the cooperation of the survey team members who participated and gave voluntarily of their time and effort to enable us to complete this large number of surveys.

As part of the CME Program, the Committee has continued its efforts to develop a computerized program with the AMA and the Academy of Medicine of New Jersey to document physician attendance at meetings. This is now in the final planning stage and shows promise of coming to fruition by January 1977.

Many requests for exemption have been received and each one has been reviewed individually by the Committee before a decision has been reached. Due to the numerous poorly documented requests that were received, letters are now being forwarded to the respective County Medical Societies for their local evaluation of the request before any action is taken. All exemptions to date have been granted on the basis of illness or physical disability preventing the physician's involvement in patient care.

Dr. James Rogers, as Consultant to the Committee on Medical Education, has compiled a preliminary report on "Continuing Medical Education — a Profile of Community Hospitals in New Jersey." Information for this report was extracted from the survey team reports and emphasizes areas that need improvement. The report also pointed up the necessity for more clearly defined criteria to improve the accreditation process. The Committee is presently working on plans to schedule a workshop of all the surveyors and Directors of Medical Education, as well as all other interested physicians, in the near future, to accomplish this goal.

In conclusion, the evaluation of CME programs in community hospitals indicates that the program is producing an improvement both in attitude, behavior, and patient care in the accredited hospitals. This trend will be carefully studied in future evaluations.

The Chairman wishes to express his appreciation to the many persons involved in the accreditation process: the hospitals, the survey team members, the members of the Committee, and to the staff, who by their valuable assistance, have contributed to the progress being made in the CME Program.

Filed (page Tr 124)

Medical Student Loan Fund

William Greifinger, M.D., Chairman, Essex

(Reference Committee "B")

In its nineteen years of operation the Medical Student Loan Fund has granted loans totaling \$442,644.35 including \$444.35 as insurance payments, bringing the net loans granted to \$442,200.

To date the Fund has issued 373 loans to 237 New Jersey medical students. One hundred and forty-nine loans have been repaid in full. Nineteen borrowers are presently making quarterly repayments on an annual basis.

Thirty-eight requests for financial assistance by New Jersey medical students were received during the 1975-1976 administrative year, and thirty loans in the amount of \$1,500 each were granted for a total of \$45,000. It is expected that this trend will continue for some time.

It is estimated that the Fund will have \$45,000 available for loans for the 1976-1977 school year to accommodate thirty students at \$1,500 each. Of this amount \$30,000 is committed to twenty re-applicants, and \$15,000 to ten new student

applications. At this time we have fifteen additional eligible applicants that the Medical Student Loan Fund cannot consider for financial aid for the fiscal year beginning June 1, 1976.

This report does not reflect all the anticipated applications from other qualified medical students and your Committee is also mindful of the ever-increasing tuition rates. However, at this time, it does not feel it can afford to increase the \$1,500 yearly loan limit.

Your Committee has had continuous, encouraging results from its solicitation of past loan recipients, now serving an internship or residency, to initiate early repayment of their loans on an interest-free basis. This year twenty-two loans have been paid in full, a total of \$21,500. The financial activities of the Fund during the year are included in the report of the Treasurer.

Your Committee warmly commends Mr. Lambert and Mr. Squireck for their consistently efficient administrative assistance.

DISTRIBUTION OF LOANS

<i>County of Residence</i>	<i>Medical School</i>	<i>Students</i>	<i>1957-75</i>	<i>1975-76 March 31, 1976</i>
Atlantic	Hahnemann	3	\$ 3,000	
	N.J. Medical	1	1,000	
	Pittsburgh	1	2,000	
	Temple	1	1,000	
	Tufts	1	4,000	
Bergen	Albert Einstein	1		\$ 1,500
	Boston	1	1,000	
	Creighton	1	1,000	
	Hahnemann	3	5,000	
	Jefferson	3	4,500	1,500
	Loyola-Stritch	1	3,000	
	Med. Coll. Pa.	1	1,500	1,500
	U. of Pa.	1		1,500
	N.J. Medical	9	14,000	
	N.Y. Medical	4	5,500	
	Rutgers	1	1,500	
	St. Louis	2	3,000	
	Tufts	1	3,000	
Burlington	Duke	1	4,000	
	Georgetown	1		1,500
	Hahnemann	2	1,000	1,500
	Jefferson	3	9,500	
	Med. Coll. Pa.	1	1,500	

Camden	Hahnemann	5	6,500	1,500
	Jefferson	3	6,500	
	Michigan	1	2,000	
	N.J. Medical	2	2,700	
	Temple	5	7,500	
	Tufts	1		
Cumberland	Jefferson	1	2,000	
Essex	Albany	1	4,000	3,000
	Bern	1	2,000	
	Creighton	2		
	Duke	1	2,000	
	Georgetown	3	4,000	
	Hahnemann	4	9,500	
	Howard	1	300	
	Jefferson	1	3,000	
	N.J. Medical	24	44,400	
	N.Y. Medical	2	2,000	
	Stanford	1	3,000	
	St. Louis	1	500	
	Temple	1	1,000	
	Tufts	1		
Gloucester	Hahnemann	1	1,000	
	Temple	1	2,000	
	Virginia U.	1	1,000	
Hudson	Boston	1	3,000	
	CMDNJ 5th Channel	1	1,500	
	Georgetown	1	1,000	
	George Washington	1	3,000	
	Hahnemann	1	1,500	
	Harvard	1	1,000	
	Howard	1	400	
	Med. Coll. Pa.	1	1,500	
	N.J. Medical	22	37,650	
	N.J. Medical	1	1,000	
	Pittsburgh	1	3,000	
	St. Louis	1	2,000	
Hunterdon	Hahnemann	1		1,500
	Rutgers	1	1,500	
Mercer	Georgetown	2	4,500	3,000
	Hahnemann	4	3,000	
	Howard	1	1,000	
	Johns Hopkins	1	1,000	
	Louisville U.	1	4,500	
	Meharry	1	250	
	Mississippi	1	3,000	
	N.J. Medical	5	9,500	
	N.Y. Medical	1	1,500	
	Pennsylvania U.	1	1,000	
	St. Louis	1	700	
	Tufts	1	1,500	
	Wisconsin Med.	1	1,500	
Middlesex	Georgetown	1	1,500	1,500
	Hahnemann	1	4,000	
	Loyola-Stitch	1	1,500	
	N.J. Medical	2	1,500	
	N.Y. Medical	2	4,500	
	Rutgers	1	3,000	
	Wisconsin Med.	1	1,500	
Monmouth	Albert Einstein	1	1,500	1,500
	Bowman Gray	1		
	Columbia	1	2,000	

Monmouth	Duke	1	3,000	
	Georgetown	1	1,000	
	Jefferson	2	6,000	
	Loyola-Stritch	1	4,500	
	Marquette	2	3,500	
	Med. Coll. Pa.	1	1,500	
	N.J. Medical	3	10,000	
	N.Y. Medical	1	4,000	
	Temple	1	2,000	
	Up-State N.Y.	1	1,000	
Morris	Case Western	1	1,500	1,500
	Dartmouth	1	1,000	
	Duke	1	1,000	
	Loyola-Stritch	1	1,500	
	Michigan	1		1,500
	N.J. Medical	3	7,500	
Ocean	Med. Coll. Pa.	1	3,000	
	Rutgers	1	3,000	
	SUNY-Downstate	1		1,500
	Tufts	1	1,500	1,500
Passaic	Jefferson	1	3,000	
	N.Y. Medical	1	1,000	
	Wisconsin Med.	2	3,000	
Salem	Duke	1	1,500	
	Jefferson	1	3,000	
Somerset	Georgetown	1	1,000	
	N.Y. Medical	1	2,000	
	Temple	1	3,000	
	Western Reserve	1	1,000	
Union	CMDNJ 5th Channel	1		1,500
	Florida	1	1,000	
	Georgetown	2		3,000
	Hahnemann	3	2,500	1,500
	Jefferson	3	1,500	3,000
	N.J. Medical	12	20,800	
	N.Y. University	2	4,500	
	Wisconsin Med.	1	3,000	
18 Counties	39 Medical	237	\$397,200	\$ 45,000
	Schools			
Total loans granted 3/31/76				\$442,200

PRESENT LOCATION OF RECIPIENTS OF LOANS

The 106 graduates are located as follows:

Interns — 4 in New Jersey and 8 out-of-state 12
 Residents — 28 in New Jersey and 17 out-of-state .. 45
 Armed Service — 5 Army of the United States and
 6 United States Navy 11

Private Practice:

2 Arizona 3 California
 1 Connecticut 2 Florida
 12 New Jersey 1 Mississippi
 1 Ohio 1 North Carolina
 6 Pennsylvania 5 New York
 1 Rhode Island 1 Texas
 1 Virginia 1 Washington D.C. 38

Students presently in medical school — 13 seniors,

16 juniors, 4 sophomores, and 1 fifth channel ... 34

Current student loans outstanding 140

Medical students paid in full (149 loans) 97

Total New Jersey Medical Students
 (as listed earlier) 237

CONTRIBUTIONS

The Committee is grateful to the many contributors to the Fund, and takes this occasion to acknowledge their support. A list of Contributors since the last report follows:

General Fund

The Medical Society of New Jersey, Board of Trustees; MSNJ's Woman's Auxiliary Executive Board; Woman's Auxiliary Fellowettes; County Medical Societies: Burlington and Monmouth. County Woman's Auxiliaries: Burlington, Camden, Cape May, Cumberland, Essex, Hudson, Mercer, Middlesex, Ocean, Passaic, Salem, Somerset, Union, and Warren. Dr. and Mrs. Samuel Baum, Dr. and Mrs. Theodore Ceraolo, Mrs. James W. Chaney, Dr. and Mrs. David Eckstein, Dr. and Mrs. S. S. Ellenson, Mrs. Don A. Epler, Dr. and Mrs. Philip Fiscella, Dr. and Mrs. Joseph R. Jehl, Dr. and Mrs. John F. Kustrup, Mrs. Norma L. Kujda,

Mrs. Marcella Mulligan, Dr. and Mrs. Paul H. Pettit, Mrs. Bernard Pinck, Mrs. John Scillieri, Dr. and Mrs. Louis Scovern, Dr. and Mrs. Joseph Shapiro, Dr. and Mrs. Ralph Wayman, Jr., Dr. and Mrs. Irving Weiss.

In Memory Of

Rev. Benjamin F. Allgood, Sotiris Athans, M.D., Bernard A. Balsis, M.D., Dr. Robert Barnett, Mrs. Helen B. Bronson, Dr. Samuel B. Brown, Eda Comanda, Dr. Carmine DeVivo, Dr. William E. Dodd, John Duffy, Mary Furey, Dr. Norman H. Gardner, Dr. Marcus H. Greifinger, Dr. George A. Hess, Charles Kiel, Anna Kochvara, Frank Kren, M.D., Albert Barker Kump Memorial, Mr. Murray Levinsohn, Dr. Alfred Meurlin, Mrs. Charles A. Minnefor, Alice Mount, Alice Nugente, Mrs. Paul A. O'Connor, Dr. Richard N. Outwin, Mrs. Samuel L. Salasin, Mrs. Jacob M. Schildkraut, Theodore F. Sheppard, Dr. George F. Simms, Mrs. Asher Yaguda, Mrs. H. York's Father.

In Honor Of

The Medical Society of New Jersey, Board of Trustees; Dr. and Mrs. Samuel Baum, John J. Bedrick, M.D. Mrs. James Brennan, Mrs. William Dodd, Mrs. Frank Doggett, Jr., Mrs. Robert Gamon, Jr., Dr. and Mrs. Seymour Nochinson, Mrs. Norman Szold, Alan J. Saperstein, Mrs. Clinton Schneder, Dr. and Mrs. Dean A. Wry, Sr., MSNJ's Woman's Auxiliary Executive Board, Past Presidents, Woman's Auxiliary to the Passaic County Medical Society,

Past Presidents, Woman's Auxiliary to the Somerset County Medical Society, Past Presidents, Woman's Auxiliary to the Warren County Medical Society.

RECOMMENDATIONS

(a) That the House of Delegates concur in the recommendation of the Finance and Budget Committee — approving a budget appropriation of six thousand dollars in lieu of a special per capita assessment for 1976-1977 in support of the Medical Student Loan Fund.

Approved (page Tr 121)

(b) That the MSNJ membership be urged to continue their active support by sending contributions to the Fund.

Approved (page Tr 121)

(c) That the Woman's Auxiliary to The Medical Society of New Jersey be requested to make the Fund its number one project next year.

Approved (page Tr 121)

Filed (page Tr 121)

Publication

Daniel B. Roth, M.D., Chairman, Teaneck

(Reference Committee "B")

The Journal of The Medical Society of New Jersey made some major changes to celebrate America's Bicentennial during the current year. Among them are the following:

1. A special cover design executed by an internationally renowned artist, William Arthur Smith.
2. A new cover logo, which places emphasis on *New Jersey* rather than *Journal*, as did the old cover.
3. A new table-of-contents page, which is clear and unencumbered.
4. The first issue was devoted largely to medical history and subsequent issues have contained pictures, editorials, articles, and short pieces of historical significance.

The work of the associate editors, manuscript review board, and book reviewers has remained high in quality. *The Journal* staff has done an ex-

emplary job in all phases of production, correspondence, and administration. Editorials have been timely, within the limitations of printing schedules, and have touched on subjects of a controversial but relevant nature.

The present advertising representatives have increased our national advertising income beyond our previous levels. The staff has remained conscious of cost-controls in order to restrain the ever-increasing deficit between *Journal* income and expenses. All facets of the financial status of *The Journal* were reviewed and it is quite clear that the major problem is inflation and the extra costs engendered by special production items. These include the Annual Meeting Program issue, House of Delegates' Transactions issue, and reports of special meetings of the House of Delegates.

Plans are being developed for future issues of *The Journal* by the Committee on Publication and the editorial staff.

Filed (page Tr 121)

Revision of Constitution and Bylaws

Hillel M. Ben-Asher, M.D., Chairman, Morristown

(Reference Committee on Constitution and Bylaws)

The Committee, after study and evaluation, submits the following report to the 1976 House of Delegates:

CONSTITUTIONAL AMENDMENTS

1. *First Year*

Because of the current Constitution, the proposed Constitution will, of necessity, be given two readings, and cannot, therefore, be formally adopted until the 1977 Annual Meeting. This proposal is really a concise statement of purposes and composition and, as such, is a skeletal outline. Those portions of the current Constitution which are of value, as well as other items, will be presented to the House in 1977 in the form of comprehensive Bylaws. Thus, there will be no gaps or vacuums and the House will be in a position next year to enact the complete compendium of Constitution and Bylaws.

Recommendation

That the attached proposed Constitution be accepted by the House of Delegates and processed for formal adoption at the 1977 Annual Meeting. (Exhibit #1)

Approved as amended by Reference Committee — see page Tr 48, this report — (page Tr 116)

2. *Second Year*

(a) *Constitution (Article IX — Officers, Section 1 — Term of Office)* (Exhibit #2)

This item was accepted by the House last year. Adoption requires a 2/3 vote. Your Committee finds it desirable.

Recommendation

That the attached amendment (Exhibit #2) concerned with the terms of MSNJ officers be adopted.

Approved (page Tr 117)

(b) *Article XII — Amendments to the Constitution* (Exhibit #3)

This proposal is also before you for second year consideration. A 2/3 vote is necessary. Your Committee finds it desirable.

Recommendation

That the attached amendment (Exhibit #3) be adopted.

Approved as amended by the Reference Committee — see page Tr 49 of this report — (page Tr 117)

BYLAWS

(a) *Bylaws, Chapter IV — House of Delegates, Section 1 — Meetings* (Exhibit #4)

Your Committee finds this change desirable and urges its enactment.

Recommendation

That the proposed Bylaw change as reflected in Exhibit #4 be adopted.

Disapproved (page Tr 118)

(b) *Bylaws, Chapter V — Procedure of Election, Section 1 — Nominating Committee* (Exhibit #5)

This proposal would, in the opinion of the Committee, provide a more democratic and knowledgeable format for elections to MSNJ posts, and assure a more open functioning of the electoral process.

Recommendation

That the proposed Bylaw change as reflected in Exhibit #5 be adopted.

Approved as amended by the Reference Committee (page Tr 118)

(In this regard, please be advised that the Committee, during the 1976-1977 Administrative Year, will be considering the recommendation of a procedure which will provide for written petitions for candidates contesting the determination of the nominating committee.)

(c) *Bylaws, Chapter XI — Component Societies, Section 2 — Qualifications of Members* (Exhibit #6)

This proposal would delete the requirement of citizenship or declaration thereof from the Bylaws. The Board of Trustees and your Committee favor its adoption.

Recommendation

That the Bylaw change proposed in Exhibit #6 be adopted.

Approved (page Tr 119)

Exhibit #1

**Proposed
Constitution of the
Medical Society of New Jersey**

Article I — Title

The name of this organization is the "Medical Society of New Jersey."

Article II — Purposes

The purposes of this Society are to promote the betterment of the public health and the science and art of medicine, to enlighten public opinion in regard to the problems of medicine, and to safeguard the rights of the practitioners of medicine.

Article III — Component Societies

County medical societies that hold charters from this Society shall be known and referred to as component societies. There shall be no more than one component society in any county of this State.

Article IV — Members

This Society is composed of individual members

of component societies and others as provided in the Bylaws.

Reference Committee recommended amendment of proposed Article IV — Members — by insertion, after the word societies, of "who are entitled to full privileges"

Approved (page Tr 117)

Article V — House of Delegates

The House of Delegates shall be the legislative and policy-making body of this Society and shall consist of Fellows, Officers, and Delegates as prescribed in the Bylaws.

Article VI — General Officers

The general officers of this Society shall be the elected officers and elected trustees as defined in the Bylaws. Their terms of office and qualifications shall be provided in the Bylaws.

Article VII — Trustees

The Board of Trustees is composed of those elected officers so designated in the Bylaws and the elected trustees, and shall constitute the executive body of the Society at such times as the House of Delegates is not in session. Its duties are those prescribed by law governing trustees of corporations and as may be prescribed in the Bylaws.

Article VIII — Sections

The House of Delegates or the Board of Trustees may provide for the division of the scientific work of this Society into sections whenever the necessity therefor arises.

Article IX — Meetings

The House of Delegates and the Scientific Sections shall meet at least annually and at such other times as are deemed necessary by the House or the Board of Trustees as provided in the Bylaws.

Article X — Funds, Dues, and Assessments

Funds shall be raised by dues and assessments on the membership as approved by the House of Delegates as provided in the Bylaws.

Article XI — Councils and Committees

Councils and Committees shall be established by the House of Delegates or the Board of Trustees as provided in the Bylaws.

Article XII — Amendments

The House of Delegates may amend this Constitution at any meeting providing that the proposed amendment shall have been circulated to the House and the component societies in writing at least 30 days prior to said meeting and a report by the Committee on Revision of Constitution and Bylaws is available to the House. A two-thirds majority of those present and voting shall be necessary for adoption.

Exhibit #1 approved as amended by the Reference Committee (page Tr 117)

Exhibit #2
Constitution
Article IX — Officers
Section 1 — Term of Office

Current	Proposed
(a) The Officers, except the Judicial Councilors and the elected members of the Board of Trustees shall hold office for one (1) year, or until their successors are elected and installed.	(a) Same
	(b) Notwithstanding any other provision of this Constitution or Bylaws, the elected Trustees, the Secretary, the Treasurer, and the members of the Judicial Council shall serve no more than three (3) three (3) year terms in any of the above-mentioned offices or combination thereof.

Approved (page Tr 117)

Exhibit #3

Constitution
Article XII — Amendments to the Constitution

Current	Proposed
This Constitution may be amended in the following manner:	Same

A. Procedure for First Year

1. Submission in writing of an amendment proposed by the Board of Trustees, by the Judicial Council, or by a component society to the Secretary of this Society not later than February first.

Reference Committee recommended amendment of foregoing proposed paragraph (1) by inserting a period after the word "Meeting" in line 9 and deleting the balance of that line and line 10.

Approved as amended by the Reference Committee (page Tr 117)

2. Transmission by the Secretary of the proposed amendment to the Standing Committee on Revision of Constitution and Bylaws and to each component society not later than February 15.

Reference Committee recommended amendment of foregoing paragraph (2) by insertion of the words "within ten (10) days" following the word "Transmission" in line 1.

Approved as amended by the Reference Committee (page Tr 117)

3. Study of the proposed amendment by the Standing Committee on Revision of Constitution and Bylaws.

4. Submission of the proposed amendment in writing at the first session of the House of Delegates.

5. Report on the proposed amendment by the Standing Committee on Revision of Constitution and Bylaws at the first session of the House of Delegates.

6. Referral of the proposed amendment and report thereon to the appropriate reference committee.

7. Hearings on the proposed amendment and report thereon by the reference committee.

8. Report of the reference committee to the final session of the House of Delegates for appropriate action.

Delete

1. Submission in writing of an amendment proposed by the Board of Trustees, by the Judicial Council, or by a component society to the Secretary of this Society not later than December 31 of the year prior to the Annual Meeting or ninety (90) days before a special meeting.

2. Transmission by the Secretary of the proposed amendment to the Standing Committee on Revision of Constitution and Bylaws and to each component society.

3. Publication of the proposed amendment in THE JOURNAL at least sixty (60) days before said meeting.

4. Submission of the report of the Standing Committee on Revision of Constitution and Bylaws concerning the proposed amendment at the first session of the House of Delegates and referral to the appropriate reference committee for hearing and study.

5. Report of the reference committee to the final session of the House of Delegates for appropriate action.

6. Acceptance by a two-thirds (2/3) vote of the House of Delegates present and voting at that final session.

7. Delete

8. Delete

9. Acceptance by a majority vote of the members of the House of Delegates present and voting at the final session.

B. Procedure for Second Year

10. Transmittal of the accepted amendment to each component society and publication in THE JOURNAL, at least three (3) months prior to the next annual meeting.

11. Adoption by a two-thirds (2/3) vote of the members of the House of Delegates present and voting at the final session.

Exhibit #3 approved as amended by the Reference Committee (page Tr 117)

Exhibit #4

Bylaws

Chapter IV — House of Delegates

Section 1 — Meetings

Current

(a) The House of Delegates shall meet on the first day of the annual meeting of this Society, but may meet in advance of or after adjournment of the annual meeting. Sessions may be adjourned from time to time, as may be necessary, but shall be so arranged as not to conflict with the general sessions and section meetings. Unless otherwise ordered by the House of Delegates, all its sessions shall be in closed session. Closed session shall include Officers, delegates, registered members and guests invited by the Chair.

(b) The annual meeting of the House of Delegates shall consist ordinarily of three (3) sessions. Except as otherwise provided, the principal business of these sessions shall be: First Session: presentation of annual reports, introduction of resolutions, introduction of new business, and assignment of same to reference committees; Second Session: report of Nominating Com-

9. Delete

B. Delete

Proposed

(a) The House of Delegates shall meet on the first day of the annual meeting of this Society, but may meet in advance of or after adjournment of the annual meeting. Sessions may be adjourned from time to time, as may be necessary, but shall be so arranged as not to conflict with the general sessions and section meetings. Unless otherwise ordered by the House of Delegates, all its sessions shall be in open session. Closed session shall include Officers, delegates, registered members and guests invited by the Chair.

Disapproved (page Tr 118)

(b) Same

mittee and election; Third Session: presentation of and action upon reports of reference committees, unfinished business, and inauguration of newly elected officers.

(c) Consent of two-thirds (2/3) of the delegates present and voting shall be required for the introduction of new business at the last session of the House of Delegates during the annual meeting, except when presented by the Board of Trustees or the Committee on Finance and Budget. All new business so presented shall require a three-fourths (3/4) affirmative vote of the delegates present and voting for adoption of new business so presented.

(c) Same

Proposed change disapproved (page Tr 118)

Exhibit #5

Bylaws

Chapter V — Procedure of Election

Section 1 — Nominating Committee

Current

(a) Each component society shall elect, at any meeting prior to March 31 of the fiscal year, one (1) of its elected delegates to serve as a member of the Nominating Committee at the next annual meeting of this Society. At the same time, each component society shall elect one (1) of its elected delegates to serve as the alternate member of the Nominating Committee.

(b) The elected member of the Nominating Committee, or in his absence the alternate member of the Nominating Committee, shall present his credentials to the Secretary before the scheduled meeting of the Nominating Committee.

Proposed

(a) Each component society shall elect at any meeting prior to March 31 of the fiscal year, one of its elected delegates to serve as a member of the Nominating Committee. At the same time, each component society shall elect one of its elected delegates to serve as the alternate member of the Nominating Committee. Nominating delegates shall serve only one elected three-year term. They may, in addition, serve a maximum of two years of an unexpired term.

Disapproved (page Tr 118)

(b) Same

(c) The Immediate Past-President of this Society shall be a member of the Nominating Committee representing the Fellows and shall serve as Chairman. If he shall not be able to serve, his immediate predecessor shall serve in his stead.

(d) The delegates, or their alternates, so elected from their respective component societies, and the representative of the Fellows shall compose the Nominating Committee. This committee shall meet in the evening of the first day of the annual meeting and report the results of its deliberations to the House of Delegates in the form of nominations for each of the offices to be filled, including Trustees elected members of committees, Councilors, Delegates and Alternate Delegates to the American Medical Association, and Delegates and Alternate Delegates to other medical organizations.

Reference Committee recommended editorial amendments to the foregoing proposed paragraph (d) as follows: insertion of the words "nominating" before the word "delegates" and of "or their" before the word "alternates" in line 1, and deletion of the word "written" in line 9.

Approved as amended (page Tr 118)

Section 2 — Procedure of Nomination

Current

(a) The Chairman of the Nominating Committee shall be the Immediate Past-President of this Society, or, in the event he is unable or unwilling to serve, a member designated by the Fellows. The committee shall elect one (1) of its own members to serve as secretary, who shall call the roll of accredited members of the committee as certified by the Secretary of this Society.

The chairman shall read to the committee this section of the Bylaws (Chapter V, Section 2) before proceeding to any other business.

(b) The Secretary of this Society shall furnish to the Committee such information as is necessary for the proper conduct of its business, including a list of all offices to be filled.

(c) Same

(d) The delegates, the alternates, and the representative of the Fellows shall comprise the Nominating Committee. The Committee shall be required to meet at least forty (40) days prior to the opening session of the Annual Meeting of the House of Delegates. Its written report of nominations for the offices being filled shall be mailed with the advance materials to the delegates and shall be printed in the MEMBERSHIP NEWSLETTER and THE JOURNAL prior to the Annual Meeting.

(a) Same

(b) Same

(c) All nominations shall be made by individual alphabetical roll call of the counties, the first county to be called to be determined by lot. This order having been established at any annual meeting shall be the order for that meeting.

The representative of each county, when his county is called, may nominate a candidate, second a nomination, or waive his privilege in favor of another county. The representative of the county so favored may then nominate a candidate, or second a nomination, after which the roll call shall be continued from the point where it was interrupted by the waiver.

The chairman shall have only the right to vote in case of a tie.

The secretary shall announce the result upon completion of each roll call. If the tabulation of any roll call be challenged by any member of the committee, the roll shall be called again. A majority vote of the members present shall nominate. In the event that no candidate has received a majority of the votes cast, the name of the candidate receiving the least number of votes shall be dropped. The call of the roll shall be repeated until a nomination is made.

(d) Nothing in this section is to be construed as preventing the nomination and election of Fellows to the Board of Trustees.

(e) The election of Trustees shall conform to the provisions of Article VI of the Constitution.

(c) The Nominating Committee meeting shall be conducted in accordance with Sturgis' "Standard Code of Parliamentary Procedure." No candidate shall be considered by the Nominating Committee unless a curriculum vitae in conformity with the form utilized by MSNJ for those seeking elective office is available to the Nominating Committee.

Approved (page Tr 119)

Delete

Delete

Delete

(d) A majority of the members present shall nominate.

Approved (page Tr 119)

(e) Delete

Section 3 — Report and Election

Current

(a) The report of the Nominating Committee, the submission of nominations from

Proposed

(a) Same

the floor by members of the House of Delegates — if any — and the election shall constitute the principal business of the second session of the House of Delegates.

(b) All elections shall be by ballot, and a majority of the votes cast shall be necessary to elect. (b) Same

(c) In the event that no candidate has received a majority of the votes cast, the name of the candidate receiving the least number of votes shall be dropped. Balloting shall be repeated until an election is made. (c) Same

(d) When an incumbent elected officer, as defined in Article IV, Section 3 of the Constitution, is elected to serve as an officer in another capacity, the presiding officer shall then declare the previous elective office vacant. This vacancy shall then be filled immediately by nomination from the floor and election by the House of Delegates. (d) Same

(e) The President-Elect shall advance to the office of President without process of nomination and election. (e) Same

Exhibit #5 approved as amended by the Reference Committee (page Tr 118)

Exhibit #6

Bylaws

Chapter XI — Component Societies

Current	Proposed
Section 2 — Qualifications of Members	Section 2 — Qualifications of Members
(a) Component societies shall have the responsibility to judge the qualifications of an applicant for any type of membership and alone shall have the power to elect him, but election thereto shall be contingent upon clearance of each eligible applicant's formal credentials as satisfactory by the Committee on Credentials of this Society.	(a) Same
(b) To be eligible for membership, the applicant must:	(b) Same
(1) be a citizen of the United States or have filed a formal declaration of intent to become a citizen;	(1) Delete
Approved (page Tr 119)	

(2) hold a degree in medicine acceptable to this Society obtained from a medical school approved by this Society at the time of his graduation; (2) Same

(3) be fully licensed to practice medicine and surgery by the New Jersey State Board of Medical Examiners; (3) Same

(4) be legally registered under that license in a county of New Jersey; (4) Same

(5) be of good moral and ethical standing; and (5) Same

(6) not support, or practice, or claim to practice any exclusive system of medicine. (6) Same

(c) When a physician applies to a component society for membership in any category, or for membership by transfer from another state, the secretary of the component society shall forward the name and address of the applicant to the biographic department of the American Medical Association for such information as may be on file relative to the applicant's record. (c) Same

(d) All records of formal actions concerning new and transfer members shall be compiled on forms to be supplied by the Committee on Credentials. (d) Same

(e) In order to retain active membership in this Society the member must hold a current Certificate in Continuing Medical Education from MSNJ's Committee on Medical Education. This Certificate will be bestowed upon members who complete acceptable programs of continuing education for a total of 150 hours in a given three-year period. This program is to be administered by the Committee on Medical Education in accordance with policy approved by the Board of Trustees and affirmed by the House of Delegates. The Committee on Medical Education, may, with the approval of the Board of Trustees, and for good cause, shown, grant specific exemptions to this subsection. (e) Same

Approved (page Tr 119)

Woman's Auxiliary Advisory

William J. Roe, M.D., Chairman, Englewood

(Reference Committee "H")

At its July 1975 meeting the Board of Trustees approved the Proposed Program of the Woman's Auxiliary for 1975-76 as submitted. There was no need for a formal meeting of this Committee during the course of the administrative year.

Administrative and routine duties as outlined in the Bylaws of the Woman's Auxiliary to The Medical Society of New Jersey were accomplished. Full minutes are preserved in the archives.

Actions felt to be significant or of a general interest are as follows:

(1) Announced priorities included emphasis on legislation and membership, health projects aimed at identified need where help is lacking, improving health education curricula in schools, and bringing an awareness of auxiliary through more visibility with their members, the Medical Society, and the public.

(2) Adopted the recommendation of the Medical Society's Committee on Medical Student Loan Fund to make this Fund a priority project for 1975-76. Through the efforts of the Auxiliary Medical Student Loan Fund chairman and the county auxiliaries a substantial contribution has been made to the Medical Student Loan Fund.

(3) Co-sponsored the state-wide eye health screening program.

(4) Conducted a Fall Workshop with emphasis on priority committees.

(5) The Board approved the Bylaws revisions as prepared by the committee for presentation to the House of Delegates at the annual meeting, and which includes a change of name from the Woman's Auxiliary to The Medical Society of New Jersey to the Medical Society of New Jersey Auxiliary.

(6) Legislation continued state Legisline program; participated in AMPAC Workshop, Washington, D.C.

(7) Maintained liaison with the Medical Society's Council on Legislation and Committee on Medical Student Loan Fund, and with JEMPAC and the College of Medicine and Dentistry.

Attended the following meetings:

AMA Auxiliary Convention, Atlantic City

AMA Auxiliary Leadership Confluence, Chicago

AMA Leadership Conference, Chicago

AMA Auxiliary Eastern Regional Conference, New York

AMPAC Public Affairs Workshop, Washington, D.C.

Designated the following meeting location:

49th Annual Meeting to be held at the Cherry Hill Inn, Cherry Hill, N.J., June 5-8, 1976

Filed (page Tr 133)

Administrative Council

Legislation

Meyer L. Abrams, M.D., Chairman, Cherry Hill

(Reference Committee "E")

This report presents a summary of the ultimate status of legislative measures of primary concern to the Society during the second session of the 1975 Legislature. The Council's operations, together with a cumulative report of MSNJ's official positions on current legislation, are reflected regularly in official bulletins dispatched to State Legislative Keymen and to component societies, and in items published in the *Membership Newsletter* and *The Journal*. The minutes of the meetings of the Board of Trustees include full reports of the Council's actions taken in regular meetings.

The Council on Legislation continues its established policy of inviting an official representative from each specialty society to all Council meetings.

Although a notice announcing the date of each of the Council's meetings is sent to all MSNJ's official intermediaries with New Jersey specialty societies, the attendance of those representatives at the Council meetings remains small. The Council urges that more representatives attend its meetings so that it may have the benefit of the timely thinking of specialty societies concerning proposed legislation affecting the specialty fields.

The Council on Legislation agreed that in order to fortify our stand on legislative bills and make our position known throughout the Society that it be a standing policy to invite the chairman of each Council and Standing Committee to attend the legislative meetings and to give them the right, if they cannot attend, to select a representative.

In compliance with the 1975 House of Delegates' directive, the Board of Trustees approved the appointment of a "Joint Ad Hoc Committee on Professional Liability" consisting of the Chairman and Vice-Chairman of the Council on Legislation, the Chairman and Vice-

Chairman of the Standing Committee on Medical Defense and Insurance, and two members-at-large, to be selected by the President from each of these respective groups.

The Committee was formed and James S. Todd, M.D., of Bergen County was appointed Chairman. Several meetings have been held and the Committee is presenting its annual report separately.

Of the bills reported to the House in 1975, the following were signed into law:

APPROVED

S-1098, S-1214, S-1387, S-1421, A-1618, A-1760 and A-2259

ACTIVE OPPOSITION

A-1552 — An act concerning medical malpractice liability insurance, requiring certain licensed medical practitioners and health care facilities to maintain such insurance, and creating a New Jersey Medical Malpractice Reinsurance Association, a New Jersey Medical Malpractice Reinsurance Recovery Fund and a New Jersey Health Care Facility Insurance Deductible Fund.

The following bills of medical interest were introduced in the 1975 Legislature, but too late to be reported to the 1975 House of Delegates:

S-3155 — To permit health insurance coverage (other than group and blanket) for outpatient treatment of the mentally ill. *ACTION DEFERRED*

S-3156 — To permit group and blanket health insurance coverage for outpatient treatment for the mentally ill. *ACTION DEFERRED*

S-3157 — To permit hospital service corporations to make available coverage for outpatient treatment of the mentally ill. *ACTION DEFERRED*

S-3158 — To provide various amendments to the act concerning the manner of disposition of cases of child abuse or neglect. *NO ACTION*

S-3161 — To delete certain restrictive provisions in the definition of podiatry under R.S. 45:5-7 permit-

ting the surgical scope of the practice to embrace the entire foot. *ACTIVE OPPOSITION*

S-3162 — To permit issuance of limited certificates for x-ray technicians in foot radiography. *ACTION DEFERRED*

S-3163 — To provide that physicians, dentists, podiatrists, optometrists and pharmacists who serve as a member of a hospital or extended care facility, hospital medical staff or peer review committee shall not be liable in damages to any person for any action taken or recommendation made by him within the scope of his function as a member of such committee. *APPROVED*

S-3164 — To provide that graduates of accelerated courses in approved colleges of podiatric medicine and surgery shall be eligible for licensure in New Jersey. *DISAPPROVED*

S-3177 — To require boards of education to identify and provide special programs for hearing-impaired children under the age of 5 and for handicapped children, classified pursuant to Article 4 of Chapter 46 of Title 18A, ages 5 through 20 years. *NO ACTION*

S-3191 — To provide that a court shall fix the fee for examinations by physicians where testimony is required in an action for injuries or where the mental or physical condition of a party is in controversy. *APPROVED*

S-3200 — To provide that when an abortion is to be performed after the 20th week of pregnancy, a physician other than the physician performing the abortion shall be in attendance to provide immediate medical care for any live child the result of the abortion, and to authorize the Commissioner of Health to promulgate rules and regulations. *DISAPPROVED*

S-3201 — To provide for the establishment of a Graduate Medical-Dental Education Program to be selected by a newly created Graduate Medical-Dental Education Board and to appropriate \$300,000. *APPROVED*

S-3223 — To provide for investigation into the deaths and examinations of infants under 3 years of age where the suspected cause is sudden infant death syndrome. *APPROVED*

S-3224 — To prescribe as a misdemeanor the performance of abortions by any method, involving the intrauterine injection of a hypertonic solution, except where the physician adjudges another method imposes an unreasonable danger to the life of the woman. *ACTIVE OPPOSITION*

S-3232 — To create a joint underwriting association to provide medical malpractice insurance on a self-supporting basis without subsidy from its members or their policyholders. *ACTION DEFERRED*

S-3239 — To permit minors, who are or profess to be afflicted with a venereal disease, or where the

minor appears to have been sexually assaulted, to consent to medical procedures. *APPROVED*

S-3246 — To establish a State catastrophic health insurance plan, to provide for the certification of health benefit plans as qualified and for the regulation of insurers and providers of health care services and to establish a health resource development fund. *ACTION DEFERRED*

S-3264 — To require physicians to report to the county prosecutor cases of suspected child abuse. *CONDITIONAL APPROVAL*

A-3268 — To define "dwelling" in the law prohibiting the use of lead paint to include day care centers and nursery schools. *APPROVED*

S-3285 — To provide that the majority of membership on professional boards and commissions shall be public members and that meetings of such shall be open to the public. *ACTIVE SUPPORT*

A-3304 — To require the Director of Motor Vehicles to provide a procedure for noting upon a driver's license that the licensee is a donor under the Uniform Anatomical Gift Act. *APPROVED*

A-3305 — To permit deposits of documents showing the nature of a gift under the Uniform Anatomical Gift Act with the Director of Motor Vehicles. *APPROVED*

A-3319 — To provide medical and health services to persons not eligible for any of the categorical assistance programs. *CONDITIONAL APPROVAL*

A-3322 — To authorize the Higher Education Assistance Authority to adjust maximum guaranteed loan limits for graduate and professional students. *APPROVED*

A-3347 — To require all group medical service contracts to provide benefits of at least \$1,000 or 50% of mental health expenses under major medical coverage. *ACTION DEFERRED*

A-3348 — To require all group health insurance policies to provide benefits at least equal in value to 60 days hospitalization and \$1,000 or 50% of mental health expenses under major medical coverage. *ACTION DEFERRED*

A-3349 — To require all group hospital service contracts to provide benefits at least equal in value to 60 days hospitalization as a result of mental illness. *ACTION DEFERRED*

A-3375 — To provide for unannounced inspections of nursing homes by the Department of Health at least twice a year. *NO ACTION*

A-3442 — To delete the prohibition against advertising the prices of prescription drugs in the act concerning the professional conduct and practice of pharmacists. *DISAPPROVED*

A-3488 — To combine amendments contained in health insurance law contained in Assembly 1503 and Assembly 22. *NO ACTION*

A-3499 — To permit minors to consent to medical procedures when in the judgment of a physician the minor appears to have been sexually assaulted. *APPROVED*

A-3531 — To permit first aid or rescue squads to display special identification lights on motor vehicles and to require the Director of Motor Vehicles to prepare suitable identification cards to be countersigned and issued by the chief executive of any municipality which must be carried by persons while emergency lights are displayed on a vehicle. *APPROVED*

Filed (page Tr 126)

Supplemental Report #1

On January 30, 1976, the following bill was signed into law as c. 297 of the Laws of 1975:

A-95—To provide that no physician shall charge a patient for completing a medical claim form in connection with a health insurance policy. *ACTIVE OPPOSITION*

In the afternoon of January 13, 1976, the First Annual Session (1976) of the 197th New Jersey Legislature was opened. As the Legislature presently is constituted, the Senate has a total of 40 members. The Senate is presently made up of 10 Republicans, 29 Democrats, and one Independent. The Assembly has a total of 80 members of whom 31 are Republicans and 49 are Democrats. By means of official legislative bulletins the Society's official positions on all current State Legislation are regularly called to the attention of legislators as well as of component societies, cooperating agencies, county keymen, and county society secretaries and executive secretaries.

The Society has adopted the following regular range of official positions concerning proposed legislation.

ACTIVE SUPPORT All-out support of the measure

ACTIVE OPPOSITION All-out opposition for the measure

CONDITIONAL APPROVAL To indicate that the approval of the Society is conditional subject to the elimination of the unsatisfactory elements of the bill that are pointed out.

APPROVAL Commended as satisfactory, but not actively supported.

DISAPPROVAL Rejected as unsatisfactory, but not actively opposed.

CURRENT STATE LEGISLATION

The Council offers this Supplemental #1 Report covering items dealt with since the compilation of its Annual Report.

S-10—To permit the courts to require medical or psychiatric treatment or term of imprisonment of up to 3 months for a second offense for operating a motor vehicle while under the influence of alcohol. *APPROVED*

S-34—To create a commission to develop a State plan for the delivery of mental health services and to appropriate \$25,000. *APPROVED*

S-35—To establish a Department of Human Services where the duties shall include development and implementation of comprehensive state plans to provide for continuity of care for all persons requesting and receiving treatment in institutions, agencies and programs under its jurisdiction, including the fullest utilization of available community resources by purchase of care and of service contracts with private agencies and individuals, to transfer various institutions and non-institutional agencies from the Department of Institutions and Agencies and to appropriate \$500,000. *NO ACTION*

S-40—To establish a Department of Mental Health in the Executive branch of government and to appropriate \$100,000. *APPROVED*

S-91—To provide for licensing of social workers. *DISAPPROVED*, because the bill would permit social workers to use medical modalities and therapeutics when they do not have the training, education, or experience to function in such a capacity.

S-93—To authorize the State Board of Higher Education to contract with Fairleigh Dickinson University School of Dentistry for acceptance of New Jersey students. *ACTION DEFERRED*, pending further information from the New Jersey Dental Association.

S-94—To create a commission to study and evaluate the State's institutions, agencies and services for the mentally ill and to appropriate \$25,000. *DISAPPROVED*, because an existing study is currently under way.

S-99—To provide for the licensing of audiologists and speech pathologists. *DISAPPROVED*, because the bill does not provide that the audiologist is to function at the direction or prescription of a duly licensed physician, a factor which is necessary for sound health care plus it is questionable whether licensing would serve any useful purpose.

S-100—To amend the Practicing Psychology Licensing Act in several respects concerning the membership on the Board, license fees and continuing education re-

quirements. *ACTION DEFERRED*, pending further information from the Council on Mental Health.

S-103—To create a joint underwriting association to provide medical malpractice insurance on a self-supporting basis without subsidy from its members or their policyholders. *NO ACTION*

S-152—To define "dwelling" in the law prohibiting the use of lead paint to include day care centers and nursery schools. *APPROVED*

S-157—To provide for retention of hospital x-ray films in any size reproductions which maintain the clarity of the original. *NO ACTION*

S-179—To require the Commissioner of Insurance to fix a time and place for a hearing upon an application of insurance rate increase or decrease and to give notice to the rating organization of which the applicant is a member and to the Director of the Division of Rate Counsel of the Department of the Public Advocate. *APPROVED*

S-212—To provide that nothing in the act concerning Health Care Facilities shall be construed as a delegation of authority to control charges made by health care facilities for services rendered except as otherwise provided. *APPROVED*

S-213—To provide that no certificate of need shall be issued or denied without approval of the Board and in the event an adverse recommendation has been issued by the State Health Planning Council, the applicant shall receive notice and be granted an opportunity for hearing. *DISAPPROVED*, because this bill would complicate the effective administration of a law that is presently complicated enough.

S-215—To create a guaranteed medical education loan program within the Higher Education Assistance Authority and to appropriate \$50,000. *APPROVED*

S-220—To authorize the expenditure of funds for the establishment and maintenance of eye bank facilities and to appropriate \$25,000 for entering into agreements with the New Jersey Eye Bank at the Newark City Hospital. *APPROVED*

S-222—To establish a Drug Utilization Review Council which shall prepare a list of interchangeable drug products and to provide that no drug shall be included in the list until after a public hearing and to appropriate \$75,000. *DISAPPROVED*, because no agency at the Federal level has been able to compose a list of therapeutically interchangeable drugs.

S-262—To provide that no health care facility shall be operated unless it shall in the case of skilled and intermediate care nursing facilities, establish and maintain a system of discharge planning which assures every patient a planned program of continuing care which meets his post-discharge needs. *NO ACTION*

S-265—To require testing of newborn infants for hearing impairments. *NO ACTION*

S-269—To provide that a court shall fix the fee for examinations by physicians where testimony is required in an action for injuries or where the mental or physical condition of a party is in controversy. *NO ACTION*

S-271—To provide that when an abortion is to be performed after the 20th week of pregnancy, a physician other than the physician performing the abortion shall be in attendance to provide immediate medical care for any live child the result of the abortion, and to authorize the Commissioner of Health to promulgate rules and regulations. *DISAPPROVED*, because the Department of Health already has authorization to promulgate such rules and regulations.

S-272—To require nursing homes to assist residents to obtain medically necessary post-discharge aid when their self-pay private insurance or Medicare capability may become sufficiently depleted to necessitate discharge. *NO ACTION*

S-274—To prescribe as a misdemeanor the performance of abortions by any method involving the intrauterine injection of a hypertonic solution except where the physician adjudges another method imposes an unreasonable danger to the life of the woman. *ACTIVE OPPOSITION*, because this bill legislates the practice of medicine without proper knowledge of the procedure involved and also because there is no evidence that this procedure, when properly administered, is any more dangerous than any other abortion procedure.

S-295—To provide for medical examination of school pupils who may be under the influence of drugs by either the medical inspector or any other doctor. *APPROVED*

S-297—To require psychological examinations before persons are appointed to a police department. *CONDITIONAL APPROVAL*, pending amendment of the bill providing that the psychological examination is conducted under the supervision of a psychiatrist.

S-299—To authorize the Department of Health to establish programs of rehabilitation for drug dependent persons, to provide facilities and to provide for licensing operators of such facilities. *DISAPPROVED*, because the legislation is unnecessary in view of the fact that the requested authority already inheres in the Department of Health and is being exercised through the Department's Division of Drug Abuse Control.

S-304—To regulate the practice of acupuncture, provide standards, qualifications and certification of practitioners. *NO ACTION*

S-318—To provide for the involuntary commitment of persons believed to be mentally ill. *ACTION DEFERRED*, pending further information from the Council on Mental Health.

S-323—To reduce the penalties for the possession and use of marijuana and hashish. *NO ACTION*

- S-324—To require county mental health boards to create the position of mental health administrator. *ACTION DEFERRED*, pending further information from the Council on Mental Health.
- S-326—To provide that a group health insurer or policyholder shall make forms for filing proof of loss readily available to an insured under a group health program. *NO ACTION*
- S-327—To permit health insurance coverage, other than group and blanket, for outpatient treatment of the mentally ill. *ACTION DEFERRED*, pending further information from the Council on Mental Health.
- S-328—To permit group and blanket health insurance coverage for outpatient treatment for the mentally ill. *ACTION DEFERRED*, pending further information from the Council on Mental Health.
- S-329—To permit hospital service corporations to make available coverage for outpatient treatment of the mentally ill. *ACTION DEFERRED*, pending further information from the Council on Mental Health.
- S-331—To provide for investigation into the deaths and examination of infants under 3 years of age where the suspected cause is sudden infant death syndrome. *NO ACTION*
- S-334—To create a 17 member "New Jersey Drug Abuse Advisory Council" within the Health Department; to repeal the Narcotic Advisory Council in the Department of Institutions and Agencies. *NO ACTION*
- S-336—To establish a personnel screening program in every State and county psychiatric hospital. *NO ACTION*
- S-378—To remove any reference to color and nationality in reporting venereal disease infections, dog bites; to delete requirements and photographs in applications for barbers' licenses and to delete need for specifying color on marriage licenses. *NO ACTION*
- S-476—To provide that any duly incorporated association, organization, league, society or other group created for the purpose of protecting dumb animals shall have the same rights, powers and privileges as are vested in New Jersey Society for Prevention of Cruelty to Animals. *NO ACTION*
- S-485—To prohibit the addition of fluorides to any municipal water supply where total fluorides from all sources in the environment exceed an average of 1.2 milligrams per day per person and to require the Department of Environmental Protection to survey all areas of the State for environmental fluoride content. *ACTION DEFERRED*, pending information from the New Jersey State Laboratory as to the toxic level of fluoride in the water.
- S-487—To include residential health care facility under the Health Care Facilities Planning Act and to direct the Commissioner of Health in consultation with the Commissioner of Institutions and Agencies annually to establish a per diem rate of compensation to be paid to public guests of residential health care facilities. *NO ACTION*
- S-490—To provide that the Commissioner of Insurance shall establish, with the approval of the Health Care Administration Board in the Department of Health, a rate review process for hospitals and institutions and other amendments to the Health Care Facilities Planning Act. *ACTION DEFERRED*, pending further information from the Joint Executive Committee of NJHA and MSNJ.
- S-502—To provide that no person shall be denied eligibility for Medical Assistance and Health Service Act benefits solely on the basis of increased social security benefits payable on or after September 1, 1972. *APPROVED*
- S-515—To exempt employees of a humane society from prohibition of the Controlled Dangerous Substances Act. *APPROVED*
- S-527—To provide that any condition or impairment of health to a uniformed member of a paid fire department caused by hypertension, heart disease or tuberculosis shall be deemed to be an occupational disease. *DISAPPROVED*, because it involves diagnosis by legislative enactment rather than by medical investigation.
- S-538—To require the Commissioner of Insurance to conduct a complete examination of hospital service corporations and hospitals with whom contracted before approving schedules of rates to be paid by subscribers. *ACTION DEFERRED*, pending further information from the Joint Executive Committee of NJHA and MSNJ.
- S-567—To provide that illnesses caused by hypertension, heart disease, tuberculosis, including coronary thrombosis, shall be deemed an occupational disease of fire and policemen. *DISAPPROVED*, because this bill involves diagnosis by legislation rather than by medical examination.
- S-568—To provide under Chapter 253, P.L. 1944 that hypertension, heart disease, tuberculosis suffered by fire and policemen shall be presumed to have been suffered in the line of duty. *DISAPPROVED*, because this bill involves diagnosis by legislation rather than by medical examination.
- S-569—To provide under Chapter 255, P.L. 1944, that hypertension, heart disease, tuberculosis suffered by fire and policemen shall be presumed to have been suffered in the line of duty. *DISAPPROVED*, because this bill involves diagnosis by legislation rather than by medical examination.
- S-599—To provide that the majority of membership on professional boards and commissions shall be public members and that meetings of such shall be open to the public. *DISAPPROVED*, in favor of S-1010.
- S-604—To limit the liability of health care providers for medical malpractice claims and to create a patients' compensation fund and a Residual Malpractice Insurance Authority. *ACTIVE SUPPORT*
- S-610—To provide that it shall be a misdemeanor for a physician to charge excessively higher fees than the normal patient fees for services in workmen's compensation or negligence action claims. *NO ACTION*

- S-611—To provide that it shall be a misdemeanor for any physician or surgeon to execute a false medical report which is subsequently submitted to any judicial or administrative proceeding. *ACTIVE SUPPORT*
- S-612—To require physicians and surgeons to provide patients with a true, accurate and itemized copy of the bill for treatment rendered where it will be the basis of a legal claim for workmen's compensation or damages in negligence. *NO ACTION*
- S-615—To require all group health insurance policies to provide benefits at least equal in value to 60 days hospitalization for mental health illness. *ACTION DEFERRED*, pending further information from the Council on Mental Health.
- S-627—To provide that no dentist shall administer a local or general anesthetic unless the State Board of Registration and Examination has certified that he has successfully passed a course in anesthesia or an examination conducted by the Board. *CONDITIONAL APPROVAL*, if reference to the word "local" is deleted.
- S-630—To require the State Department of Health to test all newborn infants for phenylketonuria. *NO ACTION*
- S-632—Designated "The Catastrophic Illness Assistance Act of 1973"; to authorize program for State assistance, appropriates \$200,000. *APPROVED*
- S-637—To establish a State catastrophic health insurance plan, to provide for the certification of health benefits plans as qualified and for the regulations of insurers and providers of health care services and to establish a health resource development fund. *ACTION DEFERRED*, pending further information from the Joint Executive Committee of NJHA and MSNJ.
- S-663—To establish the "Long-Term Care, Health Safety and Security Act" to regulate long term health care facilities. *NO ACTION*
- S-712—To include central services facilities operated by, rather than serving, institutions within definition of "health care facility" in the Health Care Facilities Planning Act. *NO ACTION*
- S-713—To provide for the registration and licensing of electrologists. *NO ACTION*
- S-715—To provide for the establishment of medical and dental education programs by the College of Medicine and Dentistry of New Jersey. *APPROVED*
- S-717—To include nursing homes and convalescent homes as health care facilities. *NO ACTION*
- S-720—To delete certain restrictive provisions in the definition of podiatry under R.S. 45:5-7 permitting the surgical scope of the practice to embrace the entire foot. *ACTIVE OPPOSITION*, because MSNJ does not believe the scope of surgery should be extended beyond what it presently encompasses.
- S-721—To permit issuance of limited certificates for x-ray technician in foot radiography. *APPROVED*
- S-722—To provide that graduates of accelerated courses in approved colleges of podiatric medicine and surgery shall be eligible for licensure in New Jersey. *APPROVED*
- S-724—To provide for the establishment of a Graduate Medical-Dental Education Program to be selected by a newly created Graduate Medical-Dental Education Board and to appropriate \$300,000. *APPROVED*
- S-736—To provide for the establishment of a central registry of blood donors in the Department of Health and to appropriate \$50,000. *DISAPPROVED*, because it would be a duplication of record keeping by existing blood banks in the State of New Jersey with no appreciable advantages.
- S-742—To authorize the Commissioner of Health to purchase residential and non-residential care and treatment of drug addicts and abusers in non-State facilities. *APPROVED*
- S-753—To provide that leaves of absence shall be granted classified civil service employees for the purpose of donating blood. *DISAPPROVED*, because MSNJ strongly supports the voluntary donation of blood. It holds that to grant a donor a day off with pay is to expose him to the same profit motivation that taints commercial blood giving.
- S-754—To provide that leaves of absence shall be granted State employees for the purpose of donating blood. *DISAPPROVED*, because MSNJ strongly supports the voluntary donation of blood. It holds that to grant a donor a day off with pay is to expose him to the same profit motivation that taints commercial blood giving.
- S-759—To provide that if the weight of alcohol in a defendant's blood is 0.07% or more, it shall be presumed that his ability to operate a motor vehicle was impaired. *APPROVED*
- S-804—To exempt from the Sales and Use Tax veterinary prescriptions and drugs, blood and its derivatives. *NO ACTION*
- S-819—To require prescription blanks for prescriptions for controlled dangerous substances to be serially numbered with the name of the prescriber printed immediately preceding the number. *DISAPPROVED*, because this bill, due to a lack of an enforceable system of accountability, would be impossible of implementation.
- S-831—To provide that the act concerning the practice of medicine and surgery shall not apply to the performance of any act at the direction and supervision of a licensed physician by a person working under a job description approved by the Board of Medical Examiners and possessing qualifications established by the Board. *DISAPPROVED*, because the scope of this bill is too broad and should be restricted.

Note: At a Board of Trustees' meeting on May 16, subsequent to preparation of this supplemental report #1, the Board changed Council's position of disapproved to *ACTION DEFERRED* pending introduction of a

resolution, by the Board, to the House of Delegates requesting that a position either for or against the use of physician-assistants and ancillary personnel be adopted.

S-832—To review the statutory law with respect to consent by minors to performance of hospital, medical or surgical procedures or treatment. *APPROVED*

S-835—To provide that the Department of Health shall prepare lists of family planning clinics in the State together with birth control information pamphlets for distribution by marriage licensing officers. *NO ACTION*

S-836—To define and include "abortion service facility" under the law concerning licensing and regulation of health care facilities. *APPROVED*

S-837—To prohibit profit-making medical referral services. *ACTIVE SUPPORT*

S-838—To limit circumstances under which a report of a referral for abortion services or of an inquiry or request therefor may be furnished. *APPROVED*

S-840—To provide that any person, other than a person licensed to practice medicine and surgery, who performs an abortifacient act shall be guilty of a high misdemeanor. *APPROVED*

S-841—To provide for the preparation and distribution of birth control information in certain cases. *NO ACTION*

S-847—To provide that the procuring, furnishing, donating, processing and distributing of human whole blood, plasma, blood products, human tissue and human organs shall not give rise to any implied warranty and the doctrine of strict tort liability shall not be applicable in any civil action brought in connection therewith. *ACTIVE SUPPORT*

S-851—To provide for the examination of pupils and amending New Jersey Statutes 18A:40-4. *APPROVED*

S-870—To create and establish a risk register for handicapped and high risk children in the Department of Health. *ACTION DEFERRED*, pending further information from the Council on Public Health.

S-882—To permit pharmacists to use discounts or rebates in sales of drugs or medications to disabled persons or those 62 years of age or older. *APPROVED*

S-888—To establish a Division of Consumer Health Services in the Department of Health. *NO ACTION*

S-889—To require physicians to report to the county prosecutor cases of suspected child abuse. *APPROVED*

Upon action of the House MSNJ position was changed to **ACTIVE OPPOSITION**

S-895—To establish a Division of Developmental Disabilities in the Department of Institutions and Agencies. *NO ACTION*

S-896—To establish a Drug Dependence Treatment and Rehabilitation Act. *NO ACTION*

S-902—To authorize the State Board of Pharmacy to give consideration to the geographical needs in granting licenses to applicants and to permit establishment of minimum and maximum prices for prescription drugs. *ACTION DEFERRED*, pending further information from the New Jersey Pharmaceutical Association.

S-903—To provide that physicians, dentists, podiatrists, optometrists and pharmacists who serve as a member of a hospital or extended care facility, hospital medical staff or peer-review committee shall not be liable in damages to any person for any action taken or recommendations made by him within the scope of his function as a member of such committee. *ACTIVE SUPPORT*

S-910—To permit the Board of Higher Education, with the advice and consent of an advisory committee, to enter into contracts with schools of optometry for acceptance of New Jersey students. *NO ACTION*

By action of the House S-910 was referred back to the Council on Legislation for reconsideration of MSNJ position.

S-918—To provide for the inclusion of eligible dental expense coverage under the State Health Benefits Program Act. *NO ACTION*

S-942—To provide for unannounced inspections of nursing homes by the Department of Health at least twice a year. *NO ACTION*

S-943—Establishes a Division of Nursing Home Ombudsman within the Department of the Public Advocate; appropriates \$150,000. *NO ACTION*

S-973—To establish a permanent Mental Health Oversight Commission. *ACTION DEFERRED*, pending further information from the Council on Mental Health.

S-976—To prohibit the Department of Environmental Protection from making any rule or regulation directing mandatory fluoridation of a public potable water supply or adjusting the fluoride content. *DISAPPROVED*, because MSNJ is in favor of the mandatory fluoridation of water.

S-992—To provide a definition of death, supplementing Title 24 of the Revised Statutes. *DISAPPROVED*, in favor of S-1039.

S-1005—To permit the advertising of retail prices of prescription drugs. *NO ACTION*

S-1006—To permit optometrists to advertise and to practice optometry in a retail or commercial store or office. *DISAPPROVED*, because the validity of advertising producing lower cost professional services has yet to be established by any responsible source and the concept, if adopted, will increase the costs of goods and services. Further, while permitting optometrists to advertise, this bill would not afford similar rights to ophthalmologists.

By action of the House S-1006 was referred back to the Council on Legislation for reconsideration of MSNJ position.

S-1007—To permit ophthalmic dispensers and technicians to advertise and to require dispensing of eyeglasses within any minimum standards and tolerances as established by the Board of Ophthalmic Dispensers and Technicians. *ACTION DEFERRED*, pending further information from the New Jersey Academy of Ophthalmology and Otolaryngology.

By action of the House *S-1007* was referred back to the Council on Legislation for reconsideration of MSNJ position.

S-1008—To reduce the apprenticeship period of ophthalmic dispensers and technicians from 4 to 2 years and to provide that such apprenticeship may be satisfied by completion of an education program beyond high school level approved by the Board of Examiners of Ophthalmic Dispensers and Ophthalmic Technicians. *ACTION DEFERRED*, pending further information from the New Jersey Academy of Ophthalmology and Otolaryngology.

By action of the House *S-1008* was referred back to the Council on Legislation for reconsideration of MSNJ position.

S-1009—To reduce from 21 to 18 years the age for admission to an examination for the practice of veterinary medicine and surgery and to provide for completion of satisfactory educational requirements or equivalent experience. *NO ACTION*

S-1010—To add a second consumer member to represent the public on the 19 professional and occupational boards under the jurisdiction of the Attorney General and the Real Estate Commission and X-Ray Technician Board of Examiners under jurisdiction of the Commissioners of Insurance and Environmental Protection. *APPROVED*

S-1011—To provide for uniform enforcement powers and procedures and standards for revocation, suspension and other disciplinary sanctions for professional and occupational boards within the Division of Consumer Affairs. *DISAPPROVED*, this bill would bypass the professional boards and superimpose the Attorney General into their regular disciplinary role. Currently the Attorney General's office has over 80 cases backlogged and the Division is not in a position to assume further original jurisdiction.

S-1031—To establish in the Department of Health a program for the identification, eradication and treatment of Beta Hemolytic Streptococcus infections and to appropriate \$300,000. *NO ACTION*

S-1033—To provide a New Jersey Life and Health Insurance Guaranty Association. *NO ACTION*

S-1039—To provide general standards for medical determination of death. *APPROVED*

S-1050—To exempt registered pharmacists 65 years of age or older from the requirements of the "Continuing Pharmaceutical Education Act." *DISAPPROVED*, because anyone actively involved in dispensing medication or treatment must be current in the practice of their profession.

S-1073—To provide for the labeling of prescription drugs showing the ingredients, directions for use, date of

issue, name of the patient, the name and address of the furnisher and the strength and quantity of the drugs. *APPROVED*

Note: At a Board of Trustees' meeting on May 16, subsequent to preparation of this supplemental report #1, the Board changed Council's position of approved to *ACTION DEFERRED*, pending discussion of the bill at the MSNJ-NJHA joint executive committee meeting.

S-1090—To require physicians, hospitals, dispensaries, asylums or similar public or private institutions to report cases of cancer to the Department of Health. *APPROVED*

S-1139—To revise the law regulating the practice of dentistry and dental hygiene. *ACTION DEFERRED*, pending further information from the New Jersey Dental Society.

S-1161—To grant physicians or surgeons immunity from liability for services rendered at the request of a police officer in cases involving persons suspected of operating a motor vehicle while under the influence of intoxicating liquor, a narcotic or a habit producing drug. *ACTIVE SUPPORT*

S-1205—To amend the "New Jersey State Health Benefits Program Act" to permit the State Health Benefits Commission to purchase certain health care benefits. *NO ACTION*

S-1213—Prescribes the nature and extent of training required of emergency mobile intensive care paramedics. *DISAPPROVED*, because the current system operative under the Department of Health is preferable and more protective of the public.

S-1219—To define "private nursing facility" and other amendments to the Health Care Facilities Planning Act. *NO ACTION*

S-1224—The "County Environmental Health Act"; to provide for establishment of county boards of health to function in all matters concerning environmental health. *NO ACTION*

S-1231—To prohibit radiologists from charging patients for interpretation of x-rays applied to a hospital when such service is covered under the patient's hospital insurance contract. *ACTIVE OPPOSITION*, because radiologists like all physicians and professionals have the right to select a fee for service practice. This bill would, if enacted, unconstitutionally deny that right. Further, it conflicts with the enabling act of Blue Cross.

S-1240—To fix the Statute of Limitations for personal injury actions at either two years from the date the act allegedly caused the injury or two years from the date the plaintiff discovered the act but in no event later than seven years from the date the act occurred and to provide for tolling these time limitations in any action against a health care provider for fraud, intentional concealment or the presence of a foreign body which has no therapeutic or diagnostic purpose or effect in the injured person. *ACTIVE SUPPORT*

S-1241—To establish a period of up to 10 years for actions based on personal injury to persons under 18 years of age. *ACTIVE SUPPORT*

S-1242—To define the rights and duties in the physician-patient relationship both inside and outside a health care facility. *ACTION DEFERRED*, pending recommended changes in the bill.

S-1243—To define the meaning of "informed consent" to a health care procedure. *ACTIVE SUPPORT*

S-1244—To require expert medical testimony concerning deviations from accepted standards in medical malpractice litigation except where a foreign substance was unintentionally left within the body of a patient during surgery or a surgical procedure was performed on the wrong patient, organ, limb or part of a patient's body where a rebuttable presumption shall occur and expert medical testimony shall not be required. *ACTIVE SUPPORT*

S-1245—To provide that a physician having knowledge of medical incompetence shall report such information to the Board of Medical Examiners. *ACTIVE SUPPORT*

By action of the House *S-1245* was referred back to the Council on Legislation for reconsideration of MSNJ position.

S-1246—To authorize the plaintiff in an action for alleged medical negligence to petition the court for a reduction of damages to the extent such costs are paid or payable or indemnified by insurance, governmental employment or service benefit programs. *ACTIVE SUPPORT*

S-1249—To appropriate \$600,000 to the College of Medicine and Dentistry for the South Jersey medical program. *ACTIVE SUPPORT*

S-1265—To provide for reimbursement of an individual who receives Medicaid assistance in the amount of ½ of any attorney's fees he may incur in maintaining an action to establish the legal liability of a third party for care and services arising out of injury, disease or disability. *DISAPPROVED*, the purpose of the Medicaid Program is the provision of health services. This bill would require Medicaid to pay for legal services and thus would drain off monies earmarked for patient care.

S-1309—To declare it the public policy of the State to encourage the development of community mental health programs in order to minimize the need for admissions and readmissions to State and county hospitals. *APPROVED*

S-1324—To provide that general public assistance shall be included in the current State operated Medicaid health care benefits program. *APPROVED*

S-1335—To provide for the establishment of a hereditary disorders program. *NO ACTION*

S-1337—To permit minors, who are, or profess to be, afflicted with a venereal disease, to consent to medical procedures where the minor appears to have been sexually assaulted. *APPROVED*

S-1341—To provide that no action may be brought on an agreement or promise of cure relating to medical

care or treatment unless such agreement or promise is in writing. *ACTIVE SUPPORT*

S-1342—To establish the Health Care Provider Liability Act concerning civil actions against health care providers and to establish a patient's compensation fund. *ACTIVE SUPPORT*

S-1354—To provide for the registration and regulation of physician assistants. *ACTIVE OPPOSITION*, the need for this type of legislation has not been clearly established, plus the role and function of physician assistants is not definitively described in that direct personal supervision is not required by this proposal.

Note: At a Board of Trustees' meeting on May 16, subsequent to the preparation of this supplemental report #1, the Board changed Council's position of active opposition to *ACTION DEFERRED*, pending introduction of a resolution, by the Board, to the House of Delegates requesting that a position either for or against the use of physician-assistants and ancillary personnel be adopted.

S-1357—To require group health insurance policies issued for delivery in New Jersey to provide for home health care. *NO ACTION*

S-1358—To require the inclusion of "home health care" coverage in hospitalization insurance policies and to supplement Chapter 26, Title 17B. *NO ACTION*

S-1360—To permit reimbursement of ½ attorney's fees incurred by Medicaid recipient maintaining certain third party actions. *DISAPPROVED*, the purpose of the Medicaid Program is the provision of health services. This bill would require Medicaid to pay for legal services and thus would drain off monies earmarked for patient care.

S-1361—To permit filing of workers' compensation claim by infant within 2 years after infant's coming of full age. *NO ACTION*

S-1362—To appropriate \$435,903 to South Jersey Medical Program Research, College of Medicine and Dentistry, Camden. *APPROVED*.

Filed (page Tr 126)

Supplemental #2

The Board of Trustees, at its May 16, 1976 meeting, voted to amend the Council on Legislation's positions on *S-831* and *S-1354* from disapproved and active opposition respectively, to one of action deferred, pending the introduction of a resolution, by the Board, to the House of Delegates requesting that a position either for or against the use of physicians' assistants and ancillary personnel be adopted. The position on *S-1073* was also amended to action deferred, pending further information from the joint Executive Committee meeting between MSNJ and NJHA.

CURRENT STATE LEGISLATION

The Council offers this Supplemental #2 Report covering items dealt with since the compilation of its Supplemental #1 Report.

S-1387—To provide for the establishment of a Graduate Medical Education Program. *APPROVED*

S-1404—To provide for confidentiality of child abuse reports and information; to provide penalties for violations. *APPROVED*

S-1419—To create a medical vision advisory panel in the Division of Motor Vehicles. *NO ACTION*

S-1423—To revise penalties for driving while intoxicated; to reduce .15% to .10% alcohol in defendant's blood to presume intoxication; to provide for a program of alcohol education or rehabilitation. *ACTION DEFERRED*, pending further information from the Committee on Alcoholism.

S-1425—To amend the law regulating the practice of pharmacy; to increase from 5 to 7 the number on Board of Pharmacy which includes one public member and to revise certain fees. *NO ACTION*

S-1442—To require all restaurants and temporary retail food establishments to have at least one employee on duty at all times trained in first aid methods of assisting persons choking. *DISAPPROVED*, because this bill is impossible of implementation.

S-1453—To provide for the establishment of a comprehensive health program in the public schools. *NO ACTION*

S-1454—To conform the Health Care Facilities Planning Act to the National Health Planning and Resources Development Act; to require 7 of the 11 members of the Health Care Administration Board to be health care services consumers and not providers and to permit the Commissioner of Health to set rates for payment by all purchasers of health care services provided by a hospital. *ACTIVE OPPOSITION*, because the expansion of the rate-setting authority of the Commissioner of Health at the present time is inadvisable since the Department of Health has yet to demonstrate that it can efficiently and effectively administer the current law. Further control and regulation while seemingly placing all insurers in the same situation will effectively stifle competition and destroy private initiative in the health insurance field.

S-1456—To permit medical service corporations to provide and insure dental services and to contract with participating dentists. *APPROVED*

A-37—To provide for consent by minors to treatment for mental illness. *DISAPPROVED*, because the bill, as written, is inherently unsound in that it calls for reliable judgment from an individual who by definition is incapable of rendering the same.

A-38—To require the certification of diagnostic information for the use of the county court at final hearings on

commitment of patients in mental hospitals where continued care and treatment beyond a 20-day temporary commitment is recommended. *APPROVED*

A-52—To provide for eye examinations of every child enrolled in the kindergarten class and to permit boards of education to authorize examinations for pupils in other grade levels. *DISAPPROVED*, because the school physician already has the obligation to screen for physical defects, including impairment of vision. The additional requirement of an optometrist or a physician licensed to practice medicine in the State of New Jersey would, in consequence, be an unjustifiable and expensive redundancy.

A-53—To direct the Board of Education to require immunization of all pupils against rubella as a condition for entrance to kindergarten and grades one through four. *DISAPPROVED*, because immunization is already mandatory in New Jersey.

A-69—To require that each bio-analytical laboratory be under supervision of a person licensed to practice medicine and surgery and certified in clinical pathology or a licensed bio-analytical laboratory director. *DISAPPROVED*, because it is not in the best interest of the public. Many physicians practicing pathology are certified in anatomical pathology, but not clinical pathology although they have extensive training in that field. Many hospital laboratories are supervised by well-qualified physicians who are not certified specialists in clinical pathology. Therefore, if this bill is enacted it will create a crisis situation in many New Jersey hospitals that are providing admirable services to the community.

Upon recommendation of the Reference Committee, House approved addition of "or good medical practice," following the word "public" in line 6 of the foregoing paragraph.

A-88—To provide for direct billing by the providers of clinical laboratory services to the recipient of the services. *DISAPPROVED*, because this concept already exists in current law.

Upon recommendation of the Reference Committee, House approved changing MSNJ position to "APPROVED."

A-111—To require, in place of permit, employment of an optometrist as school vision examiner and a physician to be known as school hearing examiner. *DISAPPROVED*, because the school physician already has the obligation to screen for physical defects, including impairment of vision. The additional requirement of an optometrist or a physician licensed to practice medicine in the State of New Jersey would, in consequence, be an unjustifiable and expensive redundancy.

A-113—To authorize the Commissioner of Education to undertake a comprehensive study of secondary education programs and facilities available to handicapped children. *NO ACTION*

A-117—To provide that the need for a certificate under the act providing for certification of x-ray technicians shall not apply to a licensed dentist and person who operates only x-ray equipment for dental

radiographs and only under the direct supervision, to provide for 9 examiners, in place of 10, on the x-ray technician board. *NO ACTION*

A-119—To provide that when a local board of health adopts more stringent health or environmental protection ordinances or regulations than imposed by the Department of Environmental Protection it must obtain the approval of the department. *APPROVED*

A-122—To provide that any person, except a licensed physician, who uses hypnosis for clinical treatment to relieve a person from symptoms of illness or unwanted habits is a disorderly person. *APPROVED*

A-135—To prohibit practitioners from dispensing methadone without approval of the Commissioner of Health after first informing him of the name of the individual to be treated and amount of methadone to be dispensed. *DISAPPROVED*, because the purpose of this bill is already superseded by Federal legislation.

A-144—To establish qualifications for laboratory directors under the Bio-Analytical Laboratory and Laboratory Directors Act in conformity with the Federal standards for such directors in Title 20, Chapter 3, Part 405 of the code of Federal regulations. *DISAPPROVED*, because this bill would lower the standards of existing statutes and would impose a costly regulation system in lieu of the high quality system already adopted in 44 other states.

A-179—To amend the "Health Care Facilities Planning Act"; to provide that no new certificate of need be required when ownership of certain health care facilities is transferred. *APPROVED*

A-181—To remove authority of Commissioner of Health to require reports re operations' costs and service utilization from health care facilities. *APPROVED*

A-193—To provide that firemen or policemen suffering disability or death from a respiratory disease shall be presumed to have been suffered in the performance of duty. *DISAPPROVED*, because it involves diagnosis by legislative enactment rather than by medical evaluation.

A-229—To prescribe that certain publications, listing or communications shall not be deemed advertising by podiatrists, physicians, surgeons, chiropractors and psychologists. *APPROVED*

A-251—To provide for examination of public school pupils suspected of being under the influence of controlled dangerous substances. *APPROVED*

A-262—To amend the law concerning operation of a motor vehicle while under the influence of narcotics to conform to the New Jersey Controlled Dangerous Substances Act. *APPROVED*

A-268—To clarify the State's ability to obtain a credit or refund of payments under the Medical Assistance and Health Services Act where an insurance company is obligated to make medical payments. *NO ACTION*

A-269—To provide that the insurance commissioner may suspend or refuse to renew an insurance license where the holder thereof has forged the name of an applicant, examining physician, witness or any instrument used with an insurance application. *NO ACTION*

A-274—To provide for the regulation of clinical laboratories. *DISAPPROVED*, because of recent amendment to the law (December 18, 1973).

A-285—To require continuing education for registered optometrists in order to qualify for renewal certificates. *NO ACTION*

A-290—To provide that the consent to medical or surgical care by a physician or to services by a public or private hospital or public clinic by a person 18 years or more of age shall be valid and binding. *NO ACTION*

A-326—To permit employees of municipal institutions holding the degree of M.D. or D.O. to apply to the Board of Medical Examiners for exemption from the act concerning the practice of medicine and surgery. *DISAPPROVED*, because MSNJ feels that it is contrary to the public interest to entrust patients to the care of unlicensed physicians other than interns and residents in approved training programs.

A-332—To provide for the Department of Mental Hygiene Act. *DISAPPROVED*, because this bill does not require that the Commissioner of this new department be a physician commiserate with the problems of the mentally ill.

A-356—To provide that any person who operates a motor vehicle shall be deemed to have given his consent to the taking of blood and urine samples for determining the content of drugs in his system. *APPROVED*

A-366—To provide that unless the prescriber explicitly specifies a brand name the pharmacist may dispense the same drug under its generic name if it reflects a lower cost to the customer. *CONDITIONAL APPROVAL*, provided the word "explicitly" is deleted from the bill.

A-390—To provide that any condition or impairment of health to a uniformed member of a paid fire department caused by hypertension, heart disease or tuberculosis shall be deemed to be an occupational disease. *DISAPPROVED*, because it involves diagnosis by legislative enactment rather than by medical investigation.

A-412—To permit qualified technical aides to perform limited medical procedures ordered by a responsible licensed physician. *ACTIVE SUPPORT*

A-414—To provide that any person arrested on violation of the Controlled Dangerous Substances Act and while on bail is again arrested in violation thereof shall not be privileged to further bail pending disposition of charges. *NO ACTION*

A-466—To provide that an act to cause miscarriage of a pregnant woman is justifiable when committed with

her consent by a duly licensed physician acting within 24 weeks of the beginning of the pregnancy or under a reasonable belief such is necessary to preserve her life. *DISAPPROVED*, as written, because the bill is not compatible with the official position of MSNJ adopted by the House of Delegates in May 1972.

A-483—To provide that no licensed chiropractor, not registered to use physiotherapy modalities, shall use such modalities. *APPROVED*

A-504—To prescribe what is a justifiable abortion and to permit physicians, medical personnel and private institutions to refuse to perform an abortion. *APPROVED*

A-536—To provide for the licensing and registration of the practice of massage and to create a Board of Massage Examiners. *DISAPPROVED*, because this bill is not of legitimate licensing interest and further would authorize chiropractors to prescribe a modality which is outside the scope of their license.

A-539—To provide for disclosure of laboratory costs to patients and third party payers. *NO ACTION*

A-677—To require inclusion of "home health care" in health insurance policies covering inpatient hospital care or skilled nursing facility care; to prohibit total dollar amount limit, separate co-insurance or separate deductible for home health care benefits. *NO ACTION*

A-679—To provide for inclusion of home health coverage in hospitalization policies. *NO ACTION*

A-685—To require every restaurant and temporary retail food establishment to have a Department of Health approved device upon the premises intended for use in removing food which becomes lodged in a person's throat. *DISAPPROVED*, because there are alternate methods for this procedure, other than the use of surgical instruments.

A-689—To authorize regional health commissions to grant and regulate licenses and permits incident to health matters. *NO ACTION*

A-730—To provide that any applicant for a medical license in addition to supplying required proofs can show that he has been engaged in a reputable practice for ten years shall be granted a license without further examination upon payment of a fee. *DISAPPROVED*, because it would abrogate the present discretionary powers of the Board to act on the basis of objective evidence and would impose an obligation to make subjective judgments as to what constitutes "proof," "reputable practice," and "conceded eminence and authority in his profession."

A-731—To provide for granting an applicant a license to practice medicine and surgery upon proving that he was examined and licensed by the appropriate body of any foreign country. *DISAPPROVED*, because it would circumvent the orderly and dependable procedure for licensing of physicians adopted by the State of New Jersey as a means of protecting the public against unqualified practitioners. It would

impose upon the State Board of Medical Examiners the almost impossible responsibility of ascertaining the standards of licensure applied in all foreign countries, and of deciding whether those standards may be accepted as equivalent to those which New Jersey imposes or to those of other states whose licenses New Jersey accepts on a basis of reciprocity.

A-957—To provide that live vertebrate animals shall not, as part of a scientific experiment, be subjected to vivisection or experimentation and to provide for humane care. *DISAPPROVED*, because it would hinder progress of scientific animal research, with jeopardy to the public welfare.

A-960—To provide for a program of pharmaceutical assistance to the disabled and to appropriate \$750,000. *APPROVED*

A-966—To prohibit smoking in any hospital patient room or patient area, elevator, indoor theater, library, art museum, concert hall, school building, school athletic facility or bus except in areas designated as smoking areas. *APPROVED*

A-967—To require health care facilities to designate not less than 30% nor more than 50% of the total number of patient rooms as "No Smoking Allowed" rooms. *DISAPPROVED*, in favor of A-966.

A-1011—To authorize first aid and rescue squad workers to display special flashing blue lights on their cars when responding to emergencies. *NO ACTION*

A-1015—To prohibit a physician or surgeon to enter into a contingent fee arrangement in any matter where medical treatment or services are rendered to form any basis of a legal claim for damages or workmen's compensation. *APPROVED*

A-1016—To provide that it shall be a misdemeanor for a physician to charge fees excessively higher than the normal patient fees for services in workmen's compensation or negligence action claims. *NO ACTION*

A-1017—To provide that it shall be a misdemeanor for any physician or surgeon to execute a false medical report which is subsequently submitted to any judicial or administrative proceeding. *ACTIVE SUPPORT*

A-1018—To require physicians and surgeons to provide patients with a true, accurate and itemized copy of the bill for treatment rendered where it will be the basis of a legal claim for workmen's compensation or damages in negligence. *NO ACTION*

A-1049—To remove the requirement that a person must be a citizen of the United States to receive a license to practice medicine or surgery in this State. *NO ACTION*

A-1050—To require the Board of Pharmacy to compile a list of the 100 most used prescription drugs and to require drug stores to post the prices for such drugs. *APPROVED*

A-1051—To delete paragraph R.S. 45:14-12(c) which prohibits the promotion of prices of prescription drugs through any media. *NO ACTION*

- A-1066*—To permit advertising of retail prices of prescription drugs and to require pharmacy posting of prices of commonly dispensed prescription drugs. *APPROVED*
- A-1067*—To require the Director of Motor Vehicles to provide a procedure for noting upon a driver's license that the licensee is a donor under the Uniform Anatomical Gift Act. *APPROVED*
- A-1068*—To permit deposits of documents showing the nature of a gift under the Uniform Anatomical Gift Act with the Director of Motor Vehicles. *APPROVED*
- A-1098*—To provide that a person who refuses to take the chemical test to determine the amount of alcohol in his blood shall not lose his driver's license unless he is convicted of violation under R.S. 39:4-50. *DISAPPROVED*
- A-1115*—To provide that no health care facility which is intended to be used or applied to the conduct of abortions shall be operated in any municipality unless a referendum on the question is held at a general election. *DISAPPROVED*, because this bill would discriminate against women desiring abortions and would force them to seek services outside of their community. Additionally, the constitutionality of such a statute is suspect in view of U.S. Supreme Court decisions on this topic.
- A-1116*—To provide that no health care facility intended to be operated as an outpatient abortion facility shall receive a certificate of need unless it can be clearly demonstrated that the outpatient facility has a written affiliation with one or more hospitals, that there is a procedure for transmitting pertinent clinical information to the hospital and that there is immediately available transportation. *APPROVED*
- A-1171*—To establish a division of alcoholism in the Department of Health, to create an advisory council, to provide for licensing of alcoholic treatment facilities, to prescribe procedures concerning arrest of an intoxicated person, to authorize establishment of a service force and to repeal and prohibit municipal ordinances prescribing penalties for public intoxication. *APPROVED*
- A-1191*—To permit preparation of a directory of physicians for consumer use which shall include the educational background, degree, fellowships, certification, specialties, experience and any other pertinent information related to the practice of medicine and surgery of the physicians. *NO ACTION*
- A-1205*—To require the inclusion of ambulance service benefits in health insurance contracts for services rendered by nonprofit municipal or volunteer first aid squads. *NO ACTION*
- A-1216*—To create a Rutgers, South Jersey Medical and Dental College Planning Council and to appropriate \$90,000. *DISAPPROVED*, because although the Society has consistently urged and strongly supported establishment of a third medical school in Southern New Jersey as soon as possible, it approved and supported the incorporation of both existing schools — at Newark and Rutgers — under the title of "The College of Medicine and Dentistry of New Jersey" and under the control of one Board of Trustees. We hold that a third school should be under the same corporate title and the same Board's control.
- A-1250*—To require all group health insurance policies to provide benefits at least equal in value to 60 days hospitalization and \$1,000 or 50% of mental health expenses under major medical coverage. *ACTION DEFERRED*, pending further information from the Council on Mental Health.
- A-1251*—To require all group hospital service contracts to provide benefits at least equal in value to 60 days hospitalization as a result of mental illness. *ACTION DEFERRED*, pending further information from the Council on Mental Health.
- A-1252*—To require all group medical service contracts to provide benefits of at least \$1,000 or 50% of mental health expenses under major medical coverage. *ACTION DEFERRED*, pending further information from the Council on Mental Health.
- A-1381*—To require a treating physician to notify the local board of health when a patient with tuberculosis in a communicable form leaves a hospital against the advice of the physician. *APPROVED*
- A-1404*—To permit municipal hospitals to employ on a salary basis physicians who do not hold New Jersey licenses. *DISAPPROVED*, because MSNJ feels that it is contrary to the public interest to entrust patients to the care of unlicensed physicians other than interns and residents in approved training programs.
- A-1425*—To provide certification as an x-ray technician for Gabrielle Smith Weinstein. *DISAPPROVED*, because this bill is in violation of our position on A-1490. Also, this bill would set a dangerous precedent for other non-trained individuals.
- A-1432*—To provide medical study scholarships for students agreeing to practice medicine in areas designated as having a shortage of physicians. *APPROVED*
- A-1450*—To repeal the "Right to Know Law" (P.L. 1963, Chapter 73) and to appropriate \$100,000. *NO ACTION*
- A-1453*—To amend the act to regulate the practice of ophthalmic dispensing. *ACTION DEFERRED*, pending further information from the New Jersey Academy of Ophthalmology and Otolaryngology.
- By action of the House A-1453 was referred back to Council on Legislation for reconsideration of MSNJ position.*
- A-1455*—To amend the "New Jersey Medical Assistance and Health Services Act," to increase criminal penalties and to provide for recovery of excessive reimbursements. *DISAPPROVED*, because this bill would create a criminal act without criminal intent.
- A-1458*—To permit advertising of retail prices of prescription drugs. *NO ACTION*

A-1459—To add a second public member to the 19 professional and occupational boards. *APPROVED*

A-1490—To provide that any person who knowingly employs an x-ray technician who requires and does not possess a valid certificate shall be guilty of a misdemeanor. *APPROVED*

A-1538—To permit ophthalmic dispensers and technicians to advertise. *ACTION DEFERRED*, pending further information from the New Jersey Academy of Ophthalmology and Otolaryngology.

By action of the House A-1538 was referred back to council on Legislation for reconsideration of MSNJ position.

A-1540—To provide uniform enforcement powers and procedures and uniform standards for revocation, suspension and other disciplinary sanctions for professional and occupational boards within the Division of Consumer Affairs. *DISAPPROVED*, because rather than creation of a new system, effective staffing and funding of the present system are indicated.

A-1575—To provide that it shall be a misdemeanor for any physician or surgeon to falsify intentionally any medical report used in workmen's compensation, negligence cases or any other type of legal proceeding. *APPROVED*

A-1615—To require pharmacists to list drugs and medicines by generic names and permit them to substitute brand names for the same prescribed-named drug with the consent of the doctor if it reflects a lower cost to the consumer. *APPROVED*

A-1629—To require sampling and testing of semi-public water supply systems by local boards of health. *APPROVED*

A-1659—To require females to take serological tests, prior to issuance of a marriage license, to determine if they ever had rubella. *ACTION DEFERRED*, pending further information from the Council on Medical Services.

A-1662—To regulate the collection, maintenance and dissemination of personal information by agencies maintaining data systems under a "Right to Privacy and Fair Information Practices Act." *NO ACTION*

A-1714—To define "private nursing facility" and to permit the Commissioner of Health to make reasonable exceptions or waivers from his rules and regulations governing nursing homes. *NO ACTION*

A-1718—To provide for the inclusion of benefits for the treatment of alcoholism in hospital service corporation contracts. *APPROVED*

A-1719—To provide for the inclusion of benefits for the treatment of alcoholism in group health insurance contracts. *APPROVED*

A-1720—To provide for the inclusion of benefits for the treatment of alcoholism in medical service corporation contracts. *APPROVED*

A-1722—To provide for the inclusion of benefits for the treatment of alcoholism in health insurance contracts. *APPROVED*

A-1733—To appropriate \$600,000 to the Department of Higher Education for the South Jersey Medical Program. *ACTIVE SUPPORT*

A-1813—To provide that an applicant is eligible to take the State medical examination if he has completed undergraduate pre-medical training in an accredited American college or university and has completed, in a foreign medical school recognized by the World Health Organization all the formal requirements of the school except a foreign internship and has completed 12 months of clinical training. *DISAPPROVED*, because it would admit to examination physicians who have not completed an internship and whose clinical training is currently recognized as being deficient.

A-1827—To remove the licensing requirement for ophthalmic technicians. *ACTION DEFERRED*, pending further information from the New Jersey Academy of Ophthalmology and Otolaryngology.

A-1864—To prohibit physician charges for surgery or related services in excess of the patient's health insurance coverage if the patient is totally incapacitated, mentally retarded, physically handicapped, a welfare recipient, on social security or covered by Medicaid or Medicare. *DISAPPROVED, WITH ACTIVE OPPOSITION IF THE BILL MOVES* because the bill violates the physician's constitutional right to contract for his services either directly with his patients or with a given hospital. Further, it is violative of the civil rights of physicians and patients. Finally, it makes little or no sense from an economic viewpoint. The mere fact that a patient is physically or mentally handicapped receiving social security payments or covered by Medicare bears no correlation to the economic resources of the individual. Millionaires and multi-millionaires could and do fall in each and/or all of the above categories.

A-1869—To include services of veterinarians and veterinary hospitals among those which can be financed through retail installment sales contracts. *NO ACTION*

A-1877—To provide workers' compensation coverage for student teachers and student nurses. *NO ACTION*

A-1881—To provide for local health purposes that State equalization aid shall be the amount per capita of the population in the area of jurisdiction, shall not be less than 50% of the capitation amount provided in the General Appropriation Act and to provide that capitation shall be \$2.50. *NO ACTION*

A-1898—To provide a subscriber, or covered dependent, under medical service corporation plan including medical services rendered by a licensed chiropractor. *ACTIVE OPPOSITION*, because the services which chiropractors are licensed to provide are not among the services covered by medical service corporations. They are not licensed or recognized as physicians or surgeons and are not qualified — or licensed — to supply medical and/or surgical services for injuries and/or disease conditions.

Filed (page Tr 126)

Administrative Council

Medical Services

Robert E. Fullilove, Jr., M.D., Chairman, Newark

(Reference Committee "F")

The Council is charged with the responsibility of studying and evaluating matters relevant to maintenance and advancement of standards and character of medical practices in New Jersey, and the investigation of the economic and social aspects of medical care.

AD HOC COMMITTEE ON NUTRITION

This Committee's concern about the extent of undesirable dietary practices as reported from highly reputable hospitals in various parts of the country led to the Hospital Based Dietary Practices Survey. This Committee was to survey trends and practices in the fifty hospitals in New Jersey that have major roles in the teaching of dietitians, nurses, and physicians. The survey was conducted during 1975 by means of a set of questionnaires — one each for (a) administration; (b) dietetic services; (c) medical services; and (d) nursing services. All fifty hospitals responded.

The major finding was the general lack of communication between the disciplines involved. More specifically, fifteen of the fifty hospitals have no stated objectives with regard to education of health professions; sixteen do not have a dietary committee; patients are weighed routinely on admission in only twenty-eight hospitals and in only three hospitals are there clear responsibilities for dietitians in the nutrition education of physicians-in-training.

The responses have been assembled and forwarded to the hospitals and agencies involved, as a first step in the plans and programs to remedy the deficiencies identified.

REIMBURSEMENT TO PHYSICIANS FOR PERFORMING UTILIZATION REVIEW FUNCTIONS — RESOLUTION #16

This resolution was referred by the 1975 House of Delegates for consideration. The Council approved that physicians should be reimbursed for performing Utilization Review Functions regarding cost containment.

COUNTERSIGNING OF HOUSE OFFICERS' HOSPITAL ORDERS AND TEMPORARY LIMITED LICENSURE

The Council considered this referral from the 1975 House of Delegates. We recommended that the Board of Trustees communicate with the State Board of Medical Examiners to bring about a ruling to provide that in all AMA approved residencies, a temporary certification will be granted to the house staff to carry on all the functions of the physician in the hospital setting, this for the first eighteen months of training, after which they would be expected to become regularly licensed.

Filed (page Tr 129)

Special Committee to Council on Medical Services

Occupational Health, Workmen's Compensation, and Rehabilitation

Elmer J. Elias, M.D., Chairman, Trenton

(Reference Committee "F")

The Committee has had no formal meeting this year and thus has no formal report to make to the House.

Filed (page Tr 129)

Administrative Council

Mental Health

Robert S. Garber, M.D., Chairman, Belle Mead

(Reference Committee "F")

The major issue that has confronted us this year is the forthcoming report of the New Jersey Mental Health Planning Committee. Our representatives on that Committee have been discouraged by constant changes in scheduled meeting dates, making it difficult to attend these meetings, and the confusion has resulted in even greater concern over the trends of the recommendations. At this writing, none of us has been privileged to see the published compendium; however, we have been led to believe that the predominant theme is anti-medicine, e.g., the recommendations limit the commitment procedure to two psychiatrists or one psychiatrist and one psychologist. Other radical recommendations will require all of the combined efforts of The Medical Society of New Jersey to moderate such legislation.

Attendance at our special committees' meetings has improved to a degree and we have even seen some new faces, with the exception of the Committee on Emotional Disorders of Childhood and Adolescence. Unless the new additions to that Committee are able to infuse new interest and activity, we may recommend that it be abolished.

Our "Subcommittee on the Sick Physician" im-

patiently awaits some sign of action, i.e., a proposal of legislation from the State Board of Medical Examiners.

Since the American Medical Association abolished its National Council on Mental Health, our own Council has felt the need to stimulate statewide interest in the plight of New Jersey's mentally ill citizens. For this reason, an ad hoc committee was appointed to develop plans for a statewide Congress on Mental Health to deal with some of the current problems in the areas of:

- (1) Anti-hospital and anti-psychiatry trends.
- (2) Right to treatment.
- (3) Civil liberty legislative proposals.
- (4) Moves to abolish public mental hospitals.

This Committee had requested funding by The Medical Society of New Jersey to implement the staging of the Congress.

The Chairman expresses gratitude to its faithful Council members and the staff of The Medical Society of New Jersey for their able assistance.

Filed (page Tr 129)

Special Committees to Council on Mental Health

Alcoholism

Robert S. Albahary, M.D., Chairman, New Brunswick

(Reference Committee "F")

The Special Committee on Alcoholism met regularly and discussed various problems connected with care of alcoholic patients in the State of New Jersey.

ALCOHOLISM PROGRAM — NEW JERSEY
STATE DEPARTMENT OF HEALTH

The Committee was given an update on the progress of the program by Mr. Kenneth Fay of

the Alcoholism Control Program. He feels that the treatment of alcoholism should be a cooperative team effort and much can be learned by the various groups communicating with each other rather than remaining completely separate entities. Mr. Fay stated that we must come closer to the client's needs. We must devise some treatment modality for the alcoholic as a whole person which will take care of all his problems. It was the general consensus of the Committee that all treatment for alcoholics must be individualized for the person.

ALCOHOL TREATMENT AND REHABILITATION
ACT — ASSEMBLY BILL #613

The Committee reviewed Assembly Bill #613 which was signed into law by Governor Byrne, February 9, 1976. Although the Committee is in agreement with the intent of the bill, they expressed their concern regarding several

provisions of the act. The Committee expressed concern that enough funds will not be available for implementation of all facets of the bill.

The Committee also feels that a majority of the eight citizen members to be appointed to the Advisory Council on Alcoholism mandated by this bill should be physicians knowledgeable in the field of alcoholism.

The fact was stressed that the bill provides for a separate Division of Alcoholism within the Department of Health with a Director and an Assistant Director, and that this should be implemented immediately since the bill is now law. This Committee will follow through on the implementation of the above concerns.

Filed (page Tr 129)

Drug Abuse

Laura E. Morrow, M.D., Chairman, Passaic
(Reference Committee "F")

While the Committee has not met as a whole, it has been in communication by telephone and letter. We have prepared, with the cooperation of the other sponsoring organizations, for the Section on Psychiatry, a program on the Addictive Process. We are also displaying an infor-

mational exhibit with the locations of Drug Abuse Centers in New Jersey and will have available literature to be taken by viewers.

Filed (page Tr 129)

Emotional Disorders of Childhood and Adolescence

Joseph J. Kline, M.D., Chairman, Trenton
(Reference Committee "F")

The Committee did not meet formally, even though meetings were scheduled. The Chairman feels that the Committee can be reorganized mainly because efforts should be made in

publicizing needs of the seriously disturbed child and resources available to respond to those needs.

Filed (page Tr 129)

Mental Retardation

Miles E. Drake, M.D., Chairman, Vineland

(Reference Committee "F")

The Committee has had no formal meeting this year and thus has no formal report to make to the House.

Filed (page Tr 129)

Neurological and Related Disorders

J. Lloyd Morrow, M.D., Chairman, Passaic

(Reference Committee "F")

The Committee on Neurological and Related Disorders has continued its studies of the incidence and treatment of spinal cord injuries throughout the State, a subject which is still of prime interest and warrants serious concern. It has appraised the most effective treatment of Parkinsonism presently known for use and has initiated through the public relations channels of the Society the widest dissemination of this information. Under serious consideration is an evaluation of the centralization of special services in neurosurgery which is receiving further study. We have collaborated with the New Jersey Consultative Services for Neurological Diseases in clarifying the intent of the law, N. S. N. J. 39:3-10.4 regarding the reporting of seizure disorder problems by physicians to the effect that only the patient with seizure disorders that are uncontrollable must be reported to the Divi-

sion of Motor Vehicles and not all patients with seizures. We have considered and approved Senate Bill #3314 which deals with what constitutes death in New Jersey. We have considered and expressed our disapproval of many of the features of the presently on-going Mental Health Planning Committee's proposals, particularly those dealing with the medical disenfranchisement of the medical physician to commit a mentally incompetent patient to an institution or place of safety and care for the welfare of himself and others. We have also succeeded in obtaining an exhibit of computerized axial tomography, which offers much promise to neurological diagnosis and treatment, for our Annual Meeting.

Filed (page Tr 129)

Administrative Council

Public Health

Robert G. Salasin, M.D., Chairman, North Wildwood

(Reference Committee "G")

Many items reviewed this year by the Council were projects specifically assigned to the various subcommittees. Those items can be found within the reports of the Special Committees on Cancer Control; Child Health; Conservation of Vision, Hearing, and Speech; Environmental Health; and Maternal and Infant Welfare.

The Board of Trustees referred to this Council, Resolution #27, "Teenage Alcohol Education." The Council discussed this Resolution for implementation. The Resolution calls for school physicians to survey the extent of the problem in their respective schools and intensify alcoholism education programs through lectures, films, and student and parent group discussion.

The Council was in full agreement with the Resolution. It was the consensus of the Council that it would not be feasible for such a survey at this time.

The Council will consider this program in the ensuing year, with cooperation from the State Board of Education and the State Department of Health.

The Council also agreed, as a first priority item, to look into "ongoing services of quality care by laboratories."

Filed (page Tr 130)

Special Committees to Council on Public Health

Cancer Control

Roy T. Forsberg, M.D., Chairman, Elizabeth

(Reference Committee "G")

The year 1975 saw the development and growth of the New Jersey Society of Oncology. There are now over 110 members of The Medical Society of New Jersey who have become members of this organization. The aims of cancer control are being stressed by this group holding seminars for education of its members and other physicians throughout the State. In

this corridor state of cancer, we have abundant talent and now for the first time this is being coordinated. A future for New Jersey in being new leaders of protocols and advancement in cancer control is very encouraging.

Filed (page Tr 131)

Child Health

Glenn P. Lambert, M.D., Chairman, Flemington

(Reference Committee "G")

The Committee had one meeting during this year, on October 29, 1975, and there was little action required. Arrangements were made for the Committee to interact with a committee of the Amateur Hockey Association of the United States regarding safety and protective equipment. Continuing interaction regarding standards established by the Division of Youth and Family Services and a youth camp safety law

were undertaken without recommendations. Communication with the New Jersey State Department of Health regarding prenatal guidelines for the recognition and prevention of immunologic disorders outlined the guidelines that the Committee felt would be worthwhile to promote.

Filed (page Tr 131)

Conservation of Vision, Hearing, and Speech

Alfonse A. Cinotti, M.D., Chairman, Jersey City

(Reference Committee "G")

The 19th Annual Eye Health Screening Program of The Medical Society of New Jersey was held during the week of September 28, 1975. A total of 91 centers participated in the program.

The number of patients screened was 10,522, of which 4,690 had a positive test. This included visual impairment, ophthalmoscopy, external conditions, and elevated intraocular pressure.

Of those screened 575 were glaucoma suspects, and a follow-up by the New Jersey State Commission for the Blind and Visually Impaired indicated the following results:

Three hundred fifty were examined by ophthalmologists. Of these, 101 were diagnosed as having glaucoma; 40 were borderline cases; and 218 were negative.

To date this program has screened 177,000 patients with 80,000 positive results. This past year approximately 1 percent of the patients who were screened were found to have glaucoma.

Recommendation

That the Committee favors establishing the Board of Governors of the New Jersey Academy of Ophthalmology and Otolaryngology as the Committee on Conservation of Vision, Hearing, and Speech of The Medical Society of New Jersey.

Not Approved (page Tr 131)

House approved a recommendation of the Reference Committee that the Board of Trustees explore closer ties with the Academy of Ophthalmology and Otolaryngology.

Filed (page Tr 131)

Environmental Health

Richard H. Musgnug, M.D., Chairman, Cherry Hill

(Reference Committee "G")

The Committee was kept informed of the health hazards of the Tocks Island Dam Project by Doctor Rozan our liaison with the Ad Hoc Committee probing these matters with the Delaware River Basin Committee and the Army Corp of Engineers. The primary areas of concern were bacterial contamination with salmonella, heavy metal accumulations, and eutrophication from blue-green algae.

The American Lung Association's proposal to study the health effects of ozone in the state was reviewed by the Committee. We suggested that a perspective study be done by setting up a statewide network of patients with known respiratory problems to act as physiological monitors. Data on environmental ozone levels could then be correlated with any significant changes in the symptoms and general state of health of these known patients.

The Committee developed an exhibit for the 1975 Annual Meeting of the Medical Society. The theme of this exhibit was "The Health Hazards of Cigarette Smoking," not only on the smoker himself but the people around him as well. The Committee was assisted in preparing and manning this exhibit by the American Lung Association and the Camden County Chapter of the American Cancer Society. The exhibit was well attended and literally thousands of pieces of informative literature were distributed.

The Committee voted to propose that the State Department of Environmental Protection purchase several electric cars which are currently available to test and evaluate their potential to replace the gasoline powered cars currently in use.

Filed (page Tr 131)

Maternal and Infant Welfare

Edward Foord, M.D., Chairman, Burlington

(Reference Committee "G")

The Committee has met twice to review reported cases of maternal mortality and will meet once again before the Annual Meeting in order to bring its deliberations up to date.

Recommended guidelines for maternity care, revised during the previous year, have been circulated following approval of the Council on Public Health and the Board of Trustees.

The members have given much time to an ongoing review of reported cases and the following conclusions would seem pertinent:

1. Maternal deaths, though markedly decreased, are still of significance.
2. The majority were considered non-preventable.
3. Many cases were significant regarding preventive care from the point of view of both patient and physician responsibility.
4. The basic function of the Committee is and has been one of objective review toward improving maternal care.

The educational function of the Committee is important and we will strive to publish selected cases in a proper fashion to achieve this function.

The Committee wishes to emphasize that its continued task has been greatly improved by effective coordination with several dedicated members of the Department of Health. Their efforts have resulted in excellent case reporting and summaries. Despite this fact, it is clear that on some occasions, case records are incomplete, a fact which must not be allowed to continue in the future.

The Committee plans to expand its membership

to encompass the proper expertise for evaluation consonant with progressive methods of maternal care.

The Chairman most sincerely thanks the Committee members and ex-officio members for their unselfish efforts to provide inspiration and ongoing effectiveness to a Committee whose function is still of signal importance to the medical profession.

Filed (page Tr 131)

Administrative Council

Public Relations

Howard D. Slobodien, M.D., Chairman, Perth Amboy

(Reference Committee "E")

The Council on Public Relations has continued its policy of adaptation to the needs of The Medical Society of New Jersey's membership and the urgencies of the times.

1. Continuing projects:

a. Publication and distribution of:

- (1) *Junior Health Hints* to schools and public libraries.
- (2) *Membership Newsletter*, including the annual compilation and distribution of a bound, indexed set to component societies.
- (3) *Periodic Newsletter* to cooperating agencies/individuals as required.

b. Preparation and publication of special news releases and publicity as required from time to time, in furtherance of the Society's business, interests, and activities, including:

- (1) The Eye Health Screening Program.

- (2) The Annual Meeting, to include the Governor's Conference.

- (3) Child Safety Week.

- (4) Selected official programs and activities.

c. Responsibility for the information center and issuance of press releases at the Annual Meeting.

- d. Responsibility for bestowal of the Golden Merit Award. 72 were bestowed in 1975, 38 in person, making a total of 881 since the award's inception in 1957.

e. Encouragement of continuance — or establishment — of orientation programs for new members under the sponsorship of component societies.

- f. Encouragement of statewide emergency medical care coverage, particularly with reference to the "Basic Concepts Underlying the Provision of Professional Medical Care" as adopted by the House of Delegates and printed in the "Appendix Reference Information" of the *Membership Directory*.

g. Encouragement of Future Physicians Clubs in each county by acting as a clearing house at State level.

h. Encouragement of increased voluntary blood donations.

i. Encouragement of radio broadcasts under the auspices of component medical societies. Plans have also been made to originate broadcasts at the Annual Meeting.

j. Encouragement of medical TV programs.

k. Diabetes Detection Week.

l. Placement service in *The Journal*. If possible, a booth will also be staffed at the Annual Meeting.

m. Physicians' Awards for Community Services:

(1) A. H. Robins Award

(2) Sheen Award

2. It was agreed to return the Golden Merit Award Ceremony to a Saturday date, because of logistic problems encountered at the Cherry Hill Convention Center.

3. It was agreed, on referral from the Board of Trustees, to work closely with the Council on Legislation to insure total coverage for major Medical Society activities. Several specific recommendations were made.

a. That the keyman system be revised.

b. That JEMPAC activities be encouraged and its efforts given wide distribution.

c. That the county societies participate more effectively in personal contact with State Legislators.

4. The major thrust on professional liability is to be assumed by a special office funded by the \$200 special voluntary assessment. The information to the public regarding various elements of the problem, such as the need for public support of our legislative efforts and the effect of higher premiums, among other factors, on health costs has been augmented by the firm of Paolin and Sweeney. This advertising firm prepared newspaper advertisements that were released on a trial basis; continuation of this activity will depend on the assessment of the membership. (This firm has also prepared posters on standard health matters for office use.)

5. It was agreed that all advertising, whether free or paid, should aim at:

a. Improvement of our public image.

b. Increasing physician participation in MSNJ activities.

c. Improving the attendance at the MSNJ convention.

6. Liaison was effected with the Committee on Medicaid and will be maintained.

7. Liaison is being developed with the New Jersey Hospital Association and the New Jersey Dental Association for joint public relations projects.

8. The following is recommended to all our membership as incorporating the most effective methods for good public relations:

a. Please read the copious literature distributed including the *Newsletter*, *The Journal*, and special releases. This would do most to relieve the so-called "communications gap."

b. The county officers and secretaries should inform their membership of information contained in the minutes and other releases sent them.

c. More of the membership should participate — at all levels.

d. Attendance at meetings of the presidents and presidents-elect should improve.

e. Trustees should be invited to meetings of the county societies.

f. Consideration should be given to county meetings with their local press representatives and with their local legislators.

g. The best public relations is on a 1 to 1 basis, not only with the press and with legislators, but most especially with patients — in the best tradition of medicine.

1776-1976 BICENTENNIAL EXHIBIT

The Council on Public Relations in cooperation with the Committee on National Bicentennial Celebration and the New Jersey Historical Society has produced and promoted an exhibit entitled "Medicine in the Era of the American Revolution." The exhibit opened at the Newark offices of the New Jersey Historical Society on February 4, 1976. It will move to Rutgers University April 1-May 27 and subsequently to the State Museum June 5-August 1, 1976. Ample media coverage has been arranged for the complete tour of the exhibit.

Filed with commendation to the Chairman (page Tr 126)

Special Committees

Chronically Ill and Aging

David Eckstein, M.D., Chairman, Trenton

(Reference Committee "G")

At the invitation of the AMA Committee on Aging, The Medical Society of New Jersey presented a seminar on the "Role of the Medical Director in the Skilled Nursing Facility" for physicians, nursing service directors, and administrators. The seminar was held in conjunction with the AMA annual convention at the Holiday Inn, Atlantic City, June 16, 1975.

The program was presented to an over-flow crowd and was well received. Registrants numbered over 300 and were about equally divided among physicians, nursing home administrators, and nursing supervisors.

The program was acceptable for 6 credit hours in Category I for the AMA Physician's Recognition Award; acceptable for 6 elective credit hours by the American Academy of Family Physicians.

Since the presentation of the program several physicians involved with long-term care have manifested an interest in participating in an ongoing educational program. The Committee plans to formulate and implement such programs.

Filed (page Tr 130)

Emergency Medical Care

Jack R. Karel, M.D., Chairman, Hillside

(Reference Committee "D")

Emergency medicine has grown as a distinct discipline and much of the progress in that area may be traced to the constant vigilance and actions of our Medical Society. The latter organization has been the catalyst for most of the improvements that have occurred in New Jersey.

HOSPITAL SIGNS

This program was first recommended by our Committee several years ago. With constant stimulation we now find hospital directional signs on major highways and thoroughfares wherever one travels in the state. The program will continue until every hospital with an emergency department has joined in this program. The State Department of Transportation has cooperated fully in placing these signs.

EMERGENCY MEDICAL SERVICE TRAINING INSTITUTE

Training programs in emergency medical services have been fragmentary in development;

an institute is necessary to coordinate them. This is especially needed in professional training programs. The New Jersey State Department of Health has the responsibility of organizing programs for the training of emergency medical technicians for ambulances. For physicians and nurses a separate *modus operandi* is required. To accomplish the development of this training institute a recommendation was made to include this project in the Implementation Plan in EMS being submitted in April 1976, by the EMS Planning Coalition Board of which the Inter-Agency Commission is a member. This was accepted.

EMERGENCY MEDICAL SERVICE COMMUNICATIONS

Unless EMS communications are properly organized throughout the state, the system will not function properly. As new frequencies are established by the Federal Communications Commission and as problems arise with interference in reception by hospitals throughout the state, some form of control is indicated that has not been evident to date. In this regard, there should

be a special frequency coordinator with authority to supervise allocation of frequencies in the state, especially as telemetry comes into usage. With the development of the latter form of communication, there should be base limitations in each county. No more than one or possibly two telemetry base-stations should be permitted in hospitals.

EMERGENCY TELEPHONES

The Medical Society of New Jersey has recommended the installation of emergency telephones on major highways and thoroughfares for a long time. This past year a pilot program was developed between Denville and Netcong. Results have not as yet been tabulated. Unfortunately the depressed economy in the state will prevent similar installations in other areas.

MEDICAL AIRLIFT SERVICES

Ever so often there is an urgent need to transfer an acutely ill or injured person by airlift. This is observed so vividly with severely burned patients. However, *before transportation of these patients is undertaken, they must be stabilized.* It was determined that we have available in New Jersey an aeromedical worldwide evacuation service for armed forces beneficiaries and civilians. Transportation is handled by the 375th Detachment Aero-medical Airlift Wing, McGuire Air Force Base. All component medical societies and the New Jersey Hospital Association were notified.

TRAINING PROGRAM FOR EMERGENCY PHYSICIANS AND NURSES

This training program started in 1974 and continued into 1975. A continuation grant application was submitted to the Health Manpower Administration for the program to be held a second year and the application was approved. However, the funding has been held up pending release of monies. Congress is conducting hearings on a continuation of PL93-174, Emergency Medical Services System Act of 1973 to 1979, and approval may bring forth funds to continue with our program.

CARDIOPULMONARY RESUSCITATION

The significance of this subject is well known to all in the medical field. With over 600,000 heart

attacks occurring across the nation yearly, there is a great need for the general public to have some basic knowledge in basic life support. To this end it was recommended that we should start with high school students and first responders, such as, police and firemen. Before proceeding with this program a sufficient number of trained instructors must be available. Because of the inadequacy of the latter and the fact that very few physicians have completed an instructor's training course in basic life support, a meeting was held by those organizations primarily involved in this subject and with emergency medicine. The consensus was that to have sufficient instructors, other organizations must participate and CPR certification should not be limited to any one organization. The following organizations may develop a certifying committee and conduct programs in Cardiopulmonary Resuscitation: American Heart Association, New Jersey Affiliate, Harriman-Metropolitan Region, American Red Cross, American College of Emergency Physicians, College of Medicine and Dentistry of New Jersey, Emergency Department Nurses Association, and the New Jersey Association of Osteopathic Physicians and Surgeons.

INTER-AGENCY COMMISSION ON EMERGENCY MEDICAL CARE

Upon the recommendations of the Special Committee on Emergency Medical Care and approval of the Board of Trustees, and under a grant from the Division of Emergency Medical Services, DHEW, the Inter-Agency Commission on Emergency Medical Care was born on April 22, 1972. A year later, the Commission was incorporated. Much has been accomplished during the past four years toward eliminating the vacuum that existed in emergency medical services. To date, major funding has come from the New Jersey Regional Medical Program, Greater Delaware Valley Regional Medical Program, and The Medical Society of New Jersey. With these funds major accomplishments have occurred this past year.

COMMUNICATIONS

Emergency medical communications' engineering studies on contract were completed in the counties of Bergen, Essex, Hudson, and Union. These had been done previously in Hunterdon

and Mercer Counties. From the studies determinations were made for the best systems for emergency medical communications in those counties, and for their eventual use in a statewide EMS communications plan.

CATEGORIZATION OF HOSPITAL EMERGENCY DEPARTMENTS

With the completion of surveys of almost all hospitals with emergency departments, data obtained were placed in the computer bank of the Hospital Research and Educational Trust of Princeton. Data from the bank were analyzed by the Committee on Emergency Departments of the Commission and adequacy determined in accordance with the categories as detailed by the American Medical Association as follows: Comprehensive Emergency Service, Major Emergency Service, General Emergency Service, and Basic Emergency Service. The vast majority of surveyed hospitals fell into Category III, General Emergency Service. The predominant reason that these hospitals were not in higher categories was that they did not have all the required major medical surgical specialties in the hospital 24 hours a day (although many had two or more specialties — e.g., general surgery or internal medicine in the hospital at all times). A second major reason was that the operating rooms were not staffed in the hospital 24 hours a day; however, almost all had operating rooms ready with complete OR staff on call (scheduled) 24 hours a day. Similarly, many Category III hospitals did not have a recovery unit staffing 24 hours a day; they had staffing whenever the unit had patients. Finally, many hospitals were in Category III because the blood bank was "elsewhere in the hospital" even if staffed 24 hours per day. This is an anomalous situation since a blood bank staffed 16 hours per day could be in Category I or II, so long as it was physically located in the emergency department. Since the survey was completed many hospitals have updated their emergency departments so that a more current survey is indicated. A new survey will show an increase of Category II and III hospitals. To date, no hospital is in Category I, Comprehensive Emergency Service.

STATE EMERGENCY MEDICAL SERVICE PLANNING COALITION

Following approval by the Division of Emergency Medical Services, DHEW and the

awarding of a grant of \$235,000 for development of an Implementation Plan for statewide emergency medical services, an EMS Planning Coalition Board was formed. This board consists of 11 members — five from state agencies, five from the Commission, and one consumer member. The Board has been meeting monthly for the purpose stated above. The Implementation Plan is to be completed by April 1976 and will be submitted to DEMS, DHEW for further funding.

EMERGENCY DEPARTMENT NURSE TRAINING PROGRAM

After many months of work, the Committee on Training in cooperation with the Emergency Department Nurses Association, New Jersey Chapter, developed a 160-hour curriculum for training of emergency department nurses. Following its completion, a grant application was submitted to the Division of Nursing, Health Resources Administration, DHEW, for a two-year program. If the grant is approved, up to three hundred nurses will receive training. Documentation from a majority of the hospitals with emergency departments indicates that the course will be oversubscribed.

MEDICOLEGAL SEMINAR

A most successful seminar was held on December 3, 1975, with participation by physicians, nurses, and hospital administrators. The lectures were given by attorneys prominent in the field of legal medicine and moderated by a former judge of the Superior Court. Since the lectures were taped and transcribed they will be in print shortly and will be distributed to those attending the seminar and to all members of The Medical Society of New Jersey.

A second annual medicolegal seminar — Pitfalls in Emergency Medical Care — will be held at the Holiday Inn of New Brunswick on September 29, 1976.

STATEWIDE EMERGENCY MEDICAL CARE PLAN

After much work during the past year, a statewide EMC plan was completed by the Commission in accordance with the 15 elements required and described in the Emergency Medical Services System Act of 1973.

Filed (page Tr 124)

Long Range Planning and Development

William J. D'Elia, M.D., Chairman, Spring Lake

(Reference Committee "A")

The Special Committee on Long Range Planning and Development has had a very active and productive year. Four meetings of the Committee were held during the 1975-76 administrative year.

LITIGATION FUND

The Committee's recommendation to establish a "Litigation Fund" was considered by the Board of Trustees on February 16, 1975. The Board referred the recommendation to the Standing Committee on Finance and Budget for further study.

The Standing Committee on Finance and Budget authorized the allocation of \$10,000 for the establishment of the "Litigation Fund." This fund will be subject to annual review by the Committee on Finance and Budget, and if and when any litigation is initiated, such action will have the prior approval of the Board of Trustees.

CONSTITUTIONAL AMENDMENT PROCEDURE

This proposal recommended by the Committee (through the Bergen County Medical Society) would reduce the Constitutional Amendment Procedure from two years to one. This amendment was presented to the 1975 House of Delegates for first year approval. It will be presented to the 1976 House of Delegates for final approval in June.

NOMINATING PROCEDURE

The Board, meeting on June 3, 1975, directed that the Committee review the guidelines for the conduct of the Nominating Committee, along with the actual nominating procedure.

The Committee was in agreement that the nominating procedure should be revised. The recommendations of the Committee have been referred by the Board to the Standing Committee on Revision of Constitution and Bylaws with the request that an appropriate amendment to the Society's Constitution and Bylaws be

prepared in order to accomplish the revisions cited by the Committee on Long Range Planning and Development.

The Committee on Revision of Constitution and Bylaws will recommend a Bylaw change to the 1976 House which will provide a more democratic and knowledgeable format for elections to MSNJ posts, and assure a more open functioning of the electoral process.

In this regard, the Committee on Revision of Constitution and Bylaws during the 1976-77 administrative year will be considering the recommendation of a procedure which will provide for written petitions for candidates contesting the determination of the Nominating Committee.

REVISED CONSTITUTION

The Committee has recommended that a simpler and more progressive Constitution is necessary for the efficient operation of the Society.

At its meeting on October 19, 1975, the Board approved the revised Constitution submitted by the Committee. The revised version has been forwarded to the Committee on Revision of Constitution and Bylaws.

Because of the wording of the current Constitution, the proposed Constitution will, of necessity, be given two readings, and cannot, therefore, be formally adopted until the 1977 Annual Meeting. This proposal is really a concise statement of purposes and composition and, as such, is a skeletal outline. Those portions of the current Constitution which are of value, as well as other items, will be presented to the House in 1977 in the form of comprehensive Bylaws. Thus, there will be no gaps or vacuums and the House will be in a position next year to enact the complete compendium of Constitution and Bylaws.

DUES AND ASSESSMENTS

This proposal would enable the House at any session to establish dues and assessments. (Currently, fiscal matters can only be acted on at the Annual Meeting.) The Committee on Revision of Constitution and Bylaws concurs that such a change is necessary to maintain a strong organization and it will develop the necessary language for 1977.

SPECIAL MEETINGS

This proposal enables the House of Delegates, when in session, to consider all items of import and does not restrict it to act only upon the specific item for which the session was called.

Obviously, such a concept is necessary to effect a meaningful Society able to respond to the needs of the membership. The Committee on Revision of Constitution and Bylaws will incorporate the appropriate language into the 1977 Bylaws.

CONFLICT OF INTEREST

The Board of Trustees did not approve of the recommendation of the Committee on Long Range Planning and Development that no active Trustee of MSNJ, or Delegate to the House, should concurrently sit on the Society's Board while serving on the State Board of Medical Examiners, the Board of Trustees of MSP, or as a full-time employee of a governmental health service program.

The Committee on Revision of Constitution and Bylaws felt that the recommendation of the Committee on Long Range Planning and Development has merit but does not believe the prohibition should extend to individual delegates. However, the problem of dual posts must be resolved and the Committee on Revision of Constitution and Bylaws will be developing appropriate language.

Filed (page Tr 120)

Medicaid

Harvey J. Shwed, M.D., Chairman, Newark

(Reference Committee "F")

The Medicaid Committee was formed as an ad hoc committee of the State Medical Society in response to the emergent issues of Medicaid cut-backs in August of 1975. The Committee explored the multiple avenues of approach and, initially, this took the form of:

(a) Information gathering — A questionnaire was sent to the membership of the State Medical Society with a response of over 3,000 members.

(b) Administrative — Committee members appeared at the public hearing on Medicaid cut-backs.

(c) Exploration of possible legal action.

(d) The educational aspects of the Medicaid program.

(e) The ad hoc committee became a standing committee of the Medical Society at the December, 1975 House of Delegates Meeting.

The Committee has been composed of representatives from county medical societies, medical specialty groups, and observer groups, such as the Pharmaceutical Association, the Podiatry Association, osteopathic physicians, and others.

The Committee meets monthly and sees its present role as follows:

1. To serve as liaison to other branches of the Medical Society on Medicaid relevant issues (e.g., the Committee has appointed liaison to the Public Relations Council and the Legislative Council.

2. The Committee sees itself as the Society's liaison to the Medicaid administration in New Jersey (e.g., the Committee will meet with Mr. Gerald Reilly, Director of the Medicaid Program in New Jersey at its next meeting at the end of April, 1976).

3. The Medicaid Committee would like to develop a "white paper" as an educational tool for the Society's 9,000 membership group, as well as legislators and administrators in the State, explaining the problems with the present health care delivery system to the poor in this State, and the role the private practitioner can

play in delivering quality health care to this group.

4. The Committee unanimously feels that it should take part in a statewide coalition of health care providers and health care advocates to serve as the spokesman for the poor in regard to health care delivery programs. The Board of Trustees of the Medical Society, at its last meeting, voted approval of this concept. At the present time, in Essex County, the Hospital and Health Planning group has planned a series of public hearings on just such a program.

Filed (page Tr 129)

Medicine and Religion

John J. Bedrick, M.D., Chairman, Bayonne

(Reference Committee "D")

The Committee has had no formal meeting this year and thus has no formal report to make to the House.

Filed (page Tr 124)

Membership Inquiries and Complaints

Joseph C. Lucci, Executive Assistant

(Reference Committee "F")

INQUIRIES AND COMPLAINTS
MAY 1, 1975 TO APRIL 1, 1976

Medicare

This Committee did not meet formally, since all complaints were resolved to the satisfaction of the physicians. A total of five complaints were received. Three complaints are pending.

Medicaid

This Committee met formally to consider one complaint out of a total of six received. All other complaints were resolved to the satisfaction of the physicians. One complaint is pending.

Medical-Surgical Plan of New Jersey

This Committee did not meet formally since all complaints were resolved to the satisfaction of the physicians. Six complaints were received. One complaint is pending.

Other Health Insurance Carriers

This Committee did not meet formally since all complaints were resolved to the satisfaction of the physicians. Six complaints were received. One complaint is pending.

Filed (page Tr 129)

Physicians' Relief Fund

Joseph J. Kline, M.D., Chairman, Trenton

(Reference Committee "B")

Your Committee has had no occasion to meet thus far this past year. One incomplete application for financial assistance was submitted. The completed application has just been received as of the writing of this report and appropriate action will be taken by your Committee.

Your Committee hopes that continued publicity will be given in the publications of the various county societies of the availability of financial assistance to members in need.

Your Committee would welcome any contribution to the Fund which would further financial support to our fellow members who may experience severe financial need.

The financial activities of the Fund during the year are included in the report of the Treasurer.

Recommendations

(a) That the House of Delegates concur in the recommendation of the Finance and Budget Committee — approving a budget appropriation of six thousand dollars in lieu of a special per capita assessment for 1976-77 in support of the Physicians' Relief Fund.

Approved (page Tr 121)

(b) That the MSNJ membership be urged to continue their active support by sending contributions to the Fund.

Approved (page Tr 121)

Filed (page Tr 121)

Professional Liability (Ad Hoc Committee)

James S. Todd, M.D., Chairman, Ridgewood

(Reference Committee "C")

The Ad Hoc Committee on Professional Liability was established by the 1975 House of Delegates and is comprised of the following: Meyer L. Abrams, M.D., Alfred A. Alessi, M.D., David R. Brewer, Jr., M.D., Irving Borsher, M.D., John J. Crosby, Jr., M.D., William J. D'Elia, M.D., John D. Franzoni, M.D., Paul J. Kreutz, M.D., John R. Tobey, M.D., and myself. In addition, at all meetings of the Committee, the presidents of the specialty societies within the State are invited to be present insuring that no position goes unnoticed.

Initially, the Committee developed a program addressing areas of legislation, physician accountability, society activity, and restructuring of the current liability financing mechanism. This program was adopted, as amended, by the Special Session of the House of Delegates in

December 1975. (See February 1976 issue of *The Journal* — MSNJ, pages 158-169 for detailed report.) Unfortunately, the House saw fit not to endorse a patient's compensation program which was the only proposal calculated immediately to have an effect upon the premium structure.

As a result of Committee activity, the following legislative measures have been introduced. Statute of Limitations (two separate bills); Res Ipsa Loquitur; Informed Consent, and Collateral Source Law. Their fate is uncertain, as there is lack of Administration support, despite a meeting with the Governor outlining our position. Equally unfortunate is the realization that even were these bills to pass unchanged, the resultant effect on premiums now would be negligible.

Consequently, the Committee continues to seek alternatives. Among the proposals being considered are: (1) Reclassification of premium structure; (2) Shift of liability from physicians to institutions in which they work; (3) Refinancing of the liability risks; and (4) Development of an insurance monopoly allowing the benefits of "claims made" policies to be utilized. Other areas of concern are education of both profession and public, development of pre-trial screening panels, establishment of a peer medical review board with ability to act upon the deviant physician, and further legislative proposals to limit physician liability.

To study and implement these concepts, there has been established a Department of Liability Control governed by the Board of Trustees, the Ad Hoc Committee, and a Director, Doctor James E. George, a member of our Society and a lawyer, as well as a physician. This group has overall responsibility to develop and implement the necessary programs. Regular newsletters will

be sent to all members of the Society in hopes of maintaining clear communications.

Despite all this additional activity, however, it is clear that the professional liability problem will not yield easily or quickly, and the membership should not expect any dramatic results overnight. The problems have arisen ever so slowly, and we bear no small responsibility for them. Our greatest concern presently is the inability or reluctance of physicians to join into a cooperative unit, each willing to give a little in order to achieve long-term benefits. It is this continuing divisiveness that is retarding, more than anything else, a prompt solution. It should be eminently clear that without unified, concerted action, continued chaos in professional liability will continue. It is the Committee's firm conviction that just as all physicians participate in the problem, so they must with forbearance and reason participate in the solution.

Filed (page Tr 123)

Retirement Plan for Physicians

Nicholas E. Marchione, M.D., Chairman, Vineland
(Reference Committee "C")

HR-10, (KEOGH) VARIABLE ANNUITY RETIREMENT INVESTMENT PLAN

In 1974, the Keogh Law was liberalized so as to permit tax-deductible contributions up to the lesser of \$7,500 or 15% of earned money. The Medical Society of New Jersey Retirement Plan Trust was modified accordingly and many members took advantage of this liberalization by increasing their contributions to the Plan and hence their tax deductions.

This Plan was established in 1970, following the success of the identical Essex County and Union County Medical Society Retirement Plan Trusts.

The program includes three unique advantages, in addition to the well-known tax-saving and tax-shelter features of the Keogh Law:

1. A lifetime monthly variable payout, based on a common-stock portfolio. (The Variable Annuity)
2. A death benefit guarantee, so that, if the participant dies during the accumulation period, his beneficiary will never receive less than the amount the participant has paid in.
3. Flexibility during accumulation years, permitting the allocation and transfer of funds, at your option, to and from the common-stock account and the fixed-dollar account.

Internal Revenue Service approval for the Master Plan (with Serial Number 701115) was received November 30th, 1970.

Throughout the state, we have 392 plans in effect covering 448 people with \$4,225,754 deposited by members of this program since its inception.

CORPORATE MASTER RETIREMENT PLAN

The Society has recognized that some of its members may see fit to practice in the form of a

corporation. Therefore, the Committee recommended, and the Society approved in 1970, the establishment of The Medical Society of New Jersey Retirement Plan Trust-B, which adopted a Corporate Master Retirement Plan, using the same funding agents as the Keogh program described above. This program, in the form of a Master Profit-Sharing Plan, permits corporations, one of whose employees is a member of the Society, to place up to 15 percent of payroll in a tax-sheltered program with the same flexibility and options as our Keogh program, using the Prudential Insurance Company's group Fixed-Dollar Annuity and group Variable Annuity. Some of the useful and valuable features of this Master Plan are described below:

1. Eligibility Requirements —
Employment 0 to 5 years —
Minimum age up to 30
2. Flexible Retirement Date (especially valuable for older corporate officers)
3. Choice of contribution formulas, including *Social Security integration*.
4. Vesting can be as minimal as nothing for the first five years under the plan and then 10% per year for the next ten years.

This plan is administered by E. & W. Blanksteen Agency, which will be pleased to furnish members with full information concerning this plan, which should provide a substantial savings, since it is not necessary to have a plan and trust specially drawn for you. Many large corporations and other organizations use these same funding agents for their tax-deferred retirement plan including that of our administrator.

PRO SERVICES, INC.

The Medical Society of New Jersey PRO Master Retirement programs provide members with pre-approved prototype plans for:

1. *Individual Retirement Accounts* (IRA) for physicians not wishing to include their employees.
2. *Self-Employed Retirement Plans* (Keogh) for self-employed physicians and partnerships.
3. *Professional Corporations* (Corporates) for physicians practicing as a corporation.

All three prototypes provide a bank as Trustee

and allow the employer and employee the right to select their own investments. The employer's investment options extend to any investment permissible under the law.

The costs are economical; to enroll, the bank charges a one-time fee of \$15 and \$18 a year per investment option. A physician may elect an economy plan, which gives him five options for \$21 per year. The bank provides all systems and record keeping in a form designed to comply with your retirement plan.

ERISA COMPLIANCE SERVICE

Under the new Employee Retirement Income Security Act of 1974 (ERISA), each employer with one or more participating employees must file a number of reports during the current year. *Reports must be filed by all such Keogh Plans — even those for which no current contributions are being deposited.*

PRO Services, Inc., has created facilities to provide the following services for a limited number of PRO Plan employers:

1. Prepare all governmental forms and reports which may be required to be filed, in a timely manner, and submit to the employer for signature and filing.
2. Prepare and submit to employees and participants such reports or other information concerning the Plan as may be required by law of regulation to be submitted on a regular basis, and also including, when specifically requested, information any such employee or participant may be entitled to request and receive from the employer.
3. Review the Plan annually from the standpoint of compliance with the contribution formula chosen in the Plan Adoption Agreement, the inclusion of employees entitled to participants, and the distribution of benefits to participants who are entitled to such distributions.
4. Send notice of, and suggestions for compliance with, any new laws, regulations or rules which may hereafter be adopted that affect the qualification of the Plan, the deductibility of contributions thereto, or the taxation of distributions therefrom.

The fee for this service is \$175 per annum, plus \$25 per participant. There is a first year one-time charge of \$100 reflecting the fact that the extra reports (Plan Description and Summary Plan Description) are required this year.

Filed (page Tr 123)

Medical-Surgical Plan of New Jersey

Joseph P. Donnelly, M.D., President, Newark

(Reference Committee "C")

YEAR OF CONTRASTS

1975: The year in which claims' payments for subscribers reached an all-time high of over \$138 million; the year in which we achieved a record membership of more than four million members; the year in which we received 2.6 million claims, more than one for every other subscriber; the year in which the number of participating physicians who provide paid-in-full services to low income subscribers reached a peak of close to 10,000. And yet 1975 was a year which we ended with a \$10.7 million operating loss and in a \$1.2 million deficit reserve position; a year in which we were awarded an inadequate rate increase; a year in which we suffered a three month strike by bargaining unit employees; and a year in which we had unprecedented recommendations for operational changes from regulatory bodies.

In short, 1975 was a year of contrasts. It was marked by more and better service to greater numbers of subscribers, and yet in many ways it was a troubled time.

IMPROVED SERVICE FOR SUBSCRIBERS AND PROVIDERS

Operating effectively at the lowest cost possible is our number one concern. Operating costs of only 12.4¢ on the dollar far exceed the return offered by commercial carriers.

We are proud that we were able to return more than 87¢ of every dollar to our subscribers in benefit payments.

Because the installation of the Cathode Ray Tube (CRT) system, begun in 1974, was completed in 1975, we were able to reduce the time needed initially to process claims. About 70 percent of all claims received were processed in 10 calendar days and 90 percent in 18 or less calendar days — a substantial improvement in service to our subscribers and providers.

The Automatic Call Distribution (ACD) equip-

ment and the System for Telephone Administration (STAR) created greater efficiency of operation in the subscriber telephone unit where some 275,000 inquiries were answered in 1975. The subscriber correspondence unit answered some 142,000 written inquiries in 1975.

A coordinated tape-to-tape program with the Prudential Insurance Company for Medicare Complementary subscribers, which has simplified the filing process and reduced processing time, was expanded from some 12,000 claims during January to some 32,500 claims during the month of December.

1975 also was a year in which more than half our membership had moved into the two better-payment programs, the Series 750 and the Usual Customary or Reasonable (UCR) Fee program.

Demonstrating our continuing concern with communications with physicians, our Professional Relations Department during 1975 personally contacted 2,555 physicians or their assistants in their offices, brought educational seminars to 1,119 physicians, met with doctors at hospitals and at meetings for a total of some 5,500 personal contacts. Our Physicians' Inquiry Unit handled more than 126,000 inquiries, including more than 85,500 written inquiries and 40,500 telephone inquiries. The ACD equipment and STAR assisted in the efficiency of this operation also.

LIBERALIZATION OF BENEFITS

In late 1975 Blue Cross and Blue Shield announced that liberalization of benefits would be made available starting in 1976 to unmarried 19 year old dependents, carrying them on family contracts to the end of the calendar year in which they became 19. In response to the critical unemployment situation in New Jersey laid-off workers with group coverage also were provided with a liberalization of regulations, making it easier for them to retain their group enrollment, or to enroll in an economical direct pay benefits package.

INTENSIFIED INTEREST IN PLAN OPERATION

Socioeconomic changes, such as intensified interest in health care delivery and financing by regulatory bodies and consumers, have caused a large increase in numbers of calls from newspaper reporters and in stories concerning the Plan. These have caused some concern from Blue Shield officials since our business is so complex that many papers have misunderstood and have at times carried incorrect information. We have endeavored to provide accurate, timely information through news releases, personal visits with editors and reporters and through our Blue Cross-Blue Shield publications.

RATE FILING NECESSARY

Because of the \$10.7 million operating loss, plans were started in late 1975 for a rate increase request, which was filed in early 1976. A review of small group monthly family rates in the Series 500 Fee program for the last 20 years showed that those rates had increased only \$1.93 since 1956, an increase of only 39 percent, while the Consumer Price Index rose some 98 percent during this period.

COST CONTAINMENT A MAJOR CONCERN

More than ever in 1975 Blue Shield was concerned with conserving the Blue Shield health care dollar, endeavoring not only to give our subscribers the best possible prepaid medical-surgical care for their money but also to make certain through stringent pre and post payment review that claims were paid properly.

The cooperation of physicians, hospital administrators and record room personnel with the utilization review department was invaluable. Without their help the utilization review program would not have been possible.

Savings in excess of \$1 million were documented by the utilization review department during 1975 through prepayment review of claims, changes in billing patterns and refunds. In addition, savings of almost \$7.9 million were achieved through the administration of the Usual, Customary or Reasonable Fee Program and through Coordination of Benefits with subscribers and other insurance programs, including the No-Fault Program and Workmen's Compensation.

Blue Shield of New Jersey will continue to seek new ways to prevent abuse or overutilization of Blue Shield benefits while encouraging subscribers to utilize their benefits properly. Subscribers and physicians alike are encouraged to "use but not abuse" Blue Shield benefits.

PURSUING OUR PURPOSE

Blue Shield of New Jersey has endeavored to initiate change as dictated by medical, economic or social forces and it will continue to explore possibilities for better serving its subscribers. But it has found no better mandate than that of the Medical Society in founding the Plan in 1942: "To make available to every man, woman and child in New Jersey adequate personal and sympathetic medical care, preventive and curative, at the lowest cost compatible with efficient services."

Physician involvement in Blue Shield is best understood in historical perspective. It was founded by physicians, and it was physicians who agreed to provide "service benefits" (paid-in-full services to low income subscribers) which was the backbone of Blue Shield. Later their participation in the Series 750 and the UCR program was the impetus for more than half of our subscribers to move up to these better-payment programs.

We are proud of our growth from 4,000 subscribers in 1942 to the more than 4 million in 1975 and we believe that physician participation and the service benefit program are largely responsible.

ANNUAL STATISTICS

Table 1

Distribution of All Underwritten Services and Payments Made in 1975

Type of Service	Total Services	% All Services	Payment	% Total Payment	Payment Per Service
Surgical	882,871	30.6	\$61,948,223	48.0	\$ 70.17
Medical	1,638,182	56.9	41,511,411	32.2	25.34*
Obstetrical	46,714	1.6	10,761,612	8.3	230.37
Consultation	100,129	3.5	2,778,708	2.2	27.75
Anesthesia	211,659	7.4	12,028,992	9.3	56.83
Total	2,879,555	100.0%	\$129,028,946	100.0%	\$ 44.81

*Includes laboratory, x-ray, physical therapy, etc.

Table 2

Distribution of Rider Services and Payments—1975

Type of Service	Services	%	Payment	%	Payment Per Service
Surgical	88,208	15.9	\$1,942,267	21.9	\$ 22.02
Medical	4,429	0.8	346,793	3.9	78.30
Diag.	202,100	36.5	3,975,172	44.8	19.67
x-Ray					
X-Ray	837	0.1	175,039	2.0	209.13
Therapy					
Physical	10,071	1.8	174,515	1.9	17.33
Therapy					
Pathology	248,763	44.9	2,265,484	25.5	9.11
Total	554,408	100.0%	\$8,879,270	100.0%	\$ 16.02

Table 3

Distribution of Earned Subscription Income

Earned Subscription Income	\$143,934,753	100.0%
Incurred Claims	138,286,109	96.1
Surgical		46.1
Medical		30.9
Obstetrical		8.1
Anesthesia		8.9
Consultation		2.1
Operating Expense	17,851,865	12.4
Underwriting Loss	(12,203,221)	(8.5)

The incidence rate for 1975 is 432 cases per 1000 persons enrolled annually

COMPARATIVE BALANCE SHEET DECEMBER 31, 1975

	1975	1974
<i>Assets</i>		
Cash in Banks and on Hand	\$ 2,926,146	\$ —
Investments	21,560,924	32,801,961
Accounts Receivable		
Subscriber Premiums	3,635,000	3,313,372
National Account Program	7,886,870	9,749,448
Federal Employee Program	2,523,377	2,937,815
Other	369,264	1,548,818
Accrued Income on Investments	366,008	509,788
Total Assets	<u>\$39,267,589</u>	<u>\$50,861,202</u>
<i>Liabilities</i>		
Provision for Medical and Surgical Claims	\$29,732,000	\$28,520,353
Excess of Outstanding Checks over		
Balance in Bank Accounts	—	1,769,181
Unearned Subscription Income	6,031,995	4,808,431
Accounts Payable	2,012,609	1,291,826
Reserve for Group Contract Settlement	546,418	3,476,352
Deposits from Organizations	2,131,352	1,910,603
Total Liabilities	<u>\$40,454,374</u>	<u>\$41,776,746</u>
<i>Reserves for Protection of Subscribers</i>		
General Reserve	\$ 100,000	\$ 100,000
Securities Evaluation	657,076	1,000,143
Unassigned	(1,943,861)	7,984,313
Total Reserves (Deficit)	<u>\$ (1,186,785)</u>	<u>\$ 9,084,456</u>
Total Liabilities and Reserves (Deficit)	<u>\$39,267,589</u>	<u>\$50,861,202</u>

COMPARATIVE STATEMENT OF OPERATIONS

	1975	1974
Subscriptions Earned	\$143,934,753	\$126,221,017
Less:		
Claims Incurred	\$138,286,109	\$116,684,111
Operating Expenses	<u>17,851,865</u>	<u>16,533,324</u>
	<u>156,137,974</u>	<u>133,217,435</u>
Loss from		
Underwriting Operations	(12,203,221)	(6,996,418)
Income on Investments	<u>1,546,083</u>	<u>2,281,583</u>
Operating Loss for the Year	<u>\$ (10,657,138)</u>	<u>\$ (4,714,835)</u>

STATEMENT OF RESERVES FOR PROTECTION OF SUBSCRIBERS

	1975		1974	
Reserves at Beginning of Year		\$ 9,084,456		\$ 14,812,217
Operating Loss for the Year		(10,657,138)		(4,714,835)
		<u>(1,572,682)</u>		<u>10,097,382</u>
Reserve Adjustments:				
Non-Admitted Assets	\$ 18,935		\$ (156,983)	
Unrealized Capital Gains (Losses)	406,415		(590,176)	
Miscellaneous	(39,453)	385,897	(265,767)	(1,012,926)
Reserves (Deficit) at End of Year		<u>\$ (1,186,785)</u>		<u>\$ 9,084,456</u>

Filed (page Tr 122)

New Jersey Participating Physicians

	Basic Percent as of 12-31		U.C.R.* Percent as of 12-31	
	1975	1974	1975	1974
By County				
Atlantic	96.3	98.1	88.6	85.6
Bergen	55.1	54.3	48.0	45.7
Burlington	95.0	94.4	82.1	76.7
Camden	90.5	90.4	82.9	81.4
Cape May	98.9	98.7	80.9	77.1
Cumberland	96.1	96.3	86.6	84.7
Essex	80.4	80.0	67.9	66.7
Gloucester	89.2	89.6	83.7	77.8
Hudson	83.8	83.7	72.7	69.7
Hunterdon	89.1	91.1	79.5	81.0
Mercer	79.2	78.4	71.6	69.9
Middlesex	74.7	73.4	62.9	60.5
Monmouth	75.5	75.5	60.3	56.9
Morris	81.9	80.6	68.3	66.4
Ocean	63.6	63.9	55.1	53.9
Passaic	78.7	78.0	67.6	64.9
Salem	97.0	96.8	92.4	87.3
Somerset	86.3	85.5	72.5	71.4
Sussex	97.0	96.9	81.4	77.1
Union	75.7	75.5	62.0	60.7
Warren	91.7	92.0	86.9	84.0
Out of state	94.7	97.1	58.1	56.0
Total	78.8	78.6	67.4	65.2
By Specialty				
Anesthesiology	61.9	60.7	65.1	62.7
Dermatology	66.1	64.3	53.7	52.5
Internal Medicine	75.4	74.5	67.7	64.7
Neurosurgery	69.0	66.7	50.8	50.0
Obstetrics-Gynecology	81.3	80.7	71.8	70.3
Ophthalmology	61.9	60.9	57.2	56.2
Orthopedic Surgery	70.6	70.3	53.9	49.4
Otolaryngology	64.8	65.3	54.8	54.6
Pathology	81.1	81.4	59.9	57.7
Pediatrics	89.2	88.9	73.4	69.8
Physical Medicine	81.2	74.3	58.3	51.3
Plastic Surgery	49.4	41.6	34.8	31.2
Bio-analytical Laboratories	82.6	84.8	66.1	64.7
Proctology	45.0	48.7	50.0	58.5
Psychiatry & Neurology	70.7	71.1	61.8	58.8
Radiology	82.4	78.5	67.5	63.0
General Surgery	78.1	78.4	68.2	66.5
Thoracic Surgery	79.4	83.5	62.7	64.5
Urology	65.7	62.5	61.5	57.6
Podiatry	93.3	93.9	78.6	78.2
General Practice	90.5	90.7	73.9	72.0
Total	78.8	78.6	67.4	65.2

*Usual, Customary or Reasonable Fee Program

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Vice-President—
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Planning and Finance

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Vice-President—Medical Affairs

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John R. Nevin (1976)
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*Ronald K. Seywert (1976)
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Charles O. Tyler, M.D. (1977)
Robert E. Verdon, M.D. (1975)

TRUSTEES EMERITUS

	<i>Appointed</i>	<i>Term as Board Member</i>
Joseph I. Echikson, M.D.	1970	1954-1970
Elton W. Lance, M.D.	1971	1962-1971
John S. Thompson	1966	1942-1965
Thomas J. White, M.D.	1973	1951-1973
Joseph M. Keating, M.D.	1975	1953-1975

ADVISORS TO TO BOARD OF TRUSTEES

	<i>Appointed</i>	<i>Term as Board Member</i>
William F. Costello, M.D.	1958	1948-1958
Andrew P. Dedick, M.D.	1973	1961-1973

CONSULTANT TO CHAIRMAN OF BOARD

	<i>Appointed</i>	<i>Term as Board Member</i>
Irving P. Borsher, M.D.	1965	1950-1965

*Resigned

†Deceased

New Jersey Foundation For Health Care Evaluation

Emanuel Abraham, M.D., President

Report to the House of Delegates, MSNJ, June 1976

At the time of our last report in June of 1975, there were three Planning PSROs in New Jersey. Now there are five funded PSROs, covering all but three counties (Bergen, Hudson, Union). Three PSROs, Area I (Morris, Sussex, Warren), Essex and Passaic are in Conditional status. Passaic Valley, as the pioneer Conditional, started review in late 1975. The program has begun to focus on New Jersey. Our Support Center contract was renewed through June 30th of this year. As review procedures move into more hospitals, and as the Planning PSROs, Central and Southern New Jersey, get ready for their turns to become Conditional, our supportive and coordinating functions will increase.

In June of 1975 the "new" regulations for Medicare and Medicaid (introduced November 1974) were confusing and clouding the atmosphere. They diverted attention away from PSRO, and threatened to remove physician-directed peer review authority and replace it with state agency control. Relief came late in the year, thanks to the injunction won by AMA. Because the sponsors of these regulations will reintroduce them, we must maintain our vigilance. The stimulus of these rules was not without benefit, since the need to update utilization techniques was brought to the attention of most "providers." Meetings, seminars, and discussions were held all over the State, and our staff was deeply involved. Physicians, hospital administrators, utilization and medical records personnel, Medicare and Medicaid agencies and intermediaries, the Department of Health, New Jersey Hospital Association and others were brought together. While each group has its turf to protect, we all learned a good deal about relating to each other in this atmosphere of change.

Last June came in a period of inflation and recession, with dismal prospects for budgets. For PSRO, HEW applied for \$50 million; Congress appropriated \$47.6 million, and subsequently overrode a Presidential veto. During this period

NJFHCE persistently sought adequate funding, so that a legitimate trial of the program could be conducted. Expressions of our concern were widely distributed; several of these appeared in the publications of MSNJ and many component societies, for which we are grateful. For New Jersey the restoration of the \$47.6 million permitted two more Conditional PSROs (Areas I and IV). It also leaves the door open for continuation of the Support Center. HEW had declared its intention to end direct funding of Support Centers as of the end of this June. Budgetary relief may permit continuing contracts for the "more effective" Support Centers. Ours has been generally recognized as one of the most effective. We appreciate the vigorous support of MSNJ in this regard. An additional transfusion was found in amendments to the Labor-HEW Act passed earlier this year. They provide for reimbursement procedures to the PSRO for hospital review. These developments indicate the intent of Congress to continue supporting the program.

A year ago the Health Planning and Resources Development Act (P.L. 93-641) was in the phase of selecting Health Service Areas. Five of these have since been designated, with the preservation of the integrity of the State borders. NJFHCE participated in the campaign to avoid absorption of four areas of New Jersey into significant metropolitan statistical areas. Health Systems Agencies have been organizing in the five areas. Since there will be specific relationships between HSAs and PSROs, we have been directing your attention to it since it went into effect early in 1975. This law will be the subject of litigation by AMA at the "appropriate" time. Nevertheless, physicians should pay close attention to it. We will maintain our contacts in the HSA areas, as well as the Division of Health Planning and Resource Development of the New Jersey Department of Health.

We indicated last year that we participate in the HMO developments via committee membership

at the State Department of Health. More planning money for HMOs was awarded in New Jersey than in any other state. This should alert you to the fact the ripples of change have indeed reached the East coast. An interesting aspect of this is the Individual Physicians Association (IPA). NJFHCE has an active committee investigating this prospect. IPA is worthy of your consideration as a method of preserving the fee-for-service basis of practice, with freedom of choice of physician and patient.

Thanks to the work of our Consortium a program was developed to provide a single, statewide data system. We have stated from the beginning our belief that the size and population density of New Jersey makes such a system appropriate. Our concern continues to be that physicians control the information concerning the quality of medical care. There have been many bids on the data proposal, which are under analysis. We thank all who participated in the Consortium: all the funded PSROs, Medicare and Medicaid representatives, fiscal intermediaries, and the New Jersey Hospital Research and Educational Trust of the New Jersey Hospital Association.

Discussions with private (non-Federal) carriers have been conducted over such mutual concerns as claims review and the eventual participation of these companies in PSRO-type review procedures.

Our staff continues to provide information, guidance, and assistance via all channels — personal visits, meetings, seminars and workshops, NJFHCE Newsletter, and the regular space generously provided us by *The Journal* and *Membership Newsletter* of MSNJ. This seems the appropriate place to express our appreciation for the splendid cooperation given us by the entire staff of MSNJ and NJAOPS. Mrs. Patricia Houston, R.N., has been very active in making her knowledge and experience in the field of utilization review available to interested parties within and outside our State. She has recently completed a definitive handbook for the Utilization Review Coordinator.

We have attracted considerable attention across the nation. We are active members of the

American Association of Professional Standards Review Organizations and the American Association of Foundations for Medical Care. We have members on several committees, including the Board of Directors of AAPSRO. Our regular reports on the meetings of the National Professional Standards Review Council in Washington are distributed nationwide by AAPSRO.

As they have since their first meetings in 1973, the members of our Board of Trustees and Executive Committee have been extremely diligent and faithful in directing our efforts, under the leadership of Emanuel Abraham, M.D., our President. Our attendance record has been outstanding. They continue to spend their evenings and Sunday mornings because they believe that physicians should respond to the challenge of P. L. 92-603 by making sure that peer review is done by practicing physicians. They also believe that representatives of practicing physicians should be in the center of developments in this era of accountability and consumerism. They believe that every new approach by government and planning agents should be scrutinized by those who have the experience, the skill — and the license — to deliver medical care. They do this, not as meek and humble servants of government, as some of our critics feel, but as representatives of their colleagues and their patients.

Thus far this resume has touched on the past and present. It is now time to look ahead at the future role of your New Jersey Foundation for Health Care Evaluation:

As in the past, the Foundation will continue to work with the PSROs, which are in varying levels of achievements. Our success in New Jersey to date can be attributed to organized medicine throughout the State and their PSRO staffs who, although independent organizations, have approached PSRO as a unified front.

The effectiveness of the Foundation in the PSRO program has been a focal point in bringing PSROs together where they share ideas and concepts and act as a harmonious staff, not only in dealing with the Federal government, but also with the other interests involved in the health

care delivery system. To this end the Foundation anticipates a more involved role with PSROs in the future, especially in terms of the review process as it progresses from the acute care facility to the nursing home facility.

In laying future plans under the PSRO program the Foundation has developed priorities for the coming year, which include:

1. Assistance in the development of new PSROs

— There are presently three unfunded areas in New Jersey in which the physician leadership has expressed an interest in securing Federal funds so that they can develop their own organizations. Among the services the Foundation can provide will be assistance in their contract application, organizational requirements, staff selections, corporate and business techniques and physicians recruitment. Foundation staff and physicians will be available to provide medical societies any technical assistance needed.

2. Assistance in the ongoing development of existing PSROs

— As the PSRO program unfurls it has become quite obvious that each PSRO area's needs are at different levels, thereby making the Foundation's role multifaceted in providing assistance to emerging PSROs. Among the varied services the Foundation will offer presently funded PSROs will be assistance in developing and negotiating memoranda of understanding with Medicare and Medicaid; hospital assessment and evaluation methods, nurse coordinator training, and allied health agency involvement. A most important project spearheaded by the Foundation will be data development and the marketing of the review system into the private sector. With regard to physician education, the Foundation will continue to disseminate its monthly *Newsletter* and *Journal* articles to over 10,000 physicians in New Jersey, highlighting PSRO activities throughout the State and nationally.

3. State Council interface — According to P. L. 92-603, with the advent of three Conditional PSROs in a state, the creation of a State Professional Standards Review Council will ensue. The representation of this Council will be drawn from each PSRO, as well as appointees from the

State medical society, hospital association, the Governor, and the Secretary of the Department of Health, Education, and Welfare.

Among the responsibilities of the State Council will be the evaluation of PSRO performance, an appeal body for disputed PSRO decisions, and a general policy-making body.

The Foundation and the PSROs will develop plans to be involved with State Council activities. HEW has only recently developed guidelines for the creation of such Councils. The Foundation feels that this organization, when created, will have a powerful effect on the New Jersey PSRO program. It is with this in mind that the future Foundation involvement will be crucial to the physician community. It is anticipated that subcontractual activities will be called for by the State Council. The creation and development of the Council will be closely monitored by the Foundation during the coming year.

4. Federal programs — PSRO coordination

— Since the Foundation's creation three years ago it has become increasingly evident the health care delivery system is in the process of change. The PSRO program completely directed by physicians appears to have the potential of not only controlling peer evaluations, but also in the development of how facilities are utilized and the flow of dollars and services needed in their community.

New Federal programs such as Health Systems Agencies, End Stage Renal Disease, and Individual Practice Associations will all make an impact in the coming years. The Foundation, through its leadership, will continue to study and recommend activities that physicians should expend their energies in pursuing.

As the PSROs grow they will successfully achieve their objectives and will have the potential to grow into other programs directly related to physician-needed decisions. The Foundation will, in the coming year, explore all the above activities as well as actively pursue goals to keep PSROs and the State's physicians abreast of the changing health care scene, both politically and socio-economically.

In preparing for next year's activities the Foundation has anticipated involvement in non-PSRO areas, for example, the Individual Practice Association, a form of pre-payment which acts as an alternative to closed panel organizations which are currently beginning to develop in New Jersey. Physician options toward the practice of medicine must be explored. As such the Foundation will study all options available and supply New Jersey physicians with information of our findings.

Other non-PSRO activities have surfaced over the last three years, especially with the State government. It has been the Foundation's fortune to be involved in the planning and monitoring of such activity. Foundation physicians are involved in such committees as the HMO Advisory Committee and the Intercouncil Data Committee sponsored by the State. Other non-PSRO involvement in the private sector includes physician membership on the Board of Managers of the New Jersey Utilization Project.

It is anticipated that Foundation staff will become more involved not only in State and local projects, but also nationally where New Jersey has demonstrated leadership capabilities to the rest of the country in dealing with the changing health care scene.

The Foundation extends its gratitude to the physicians of The Medical Society of New Jersey and the New Jersey Association of Osteo-

pathic Physicians and Surgeons for their past support and future involvement.

Our role, as we see it, is to continue to represent New Jersey physicians in dealing with all of the foregoing categories of influences on medical care:

- Utilization review
- Training of physicians and other personnel
- Alternative avenues of access, including Individual Practice Associations
- Private review
- Participation in New Jersey Department of Health functions and committees

We will need to be involved with or without Federal money. We will be eligible for a continuation of our Federal contract through September 30, 1977, but we cannot predict the amount to be awarded. The endorsement and financial support of MSNJ and NJAOPS affords us a flexibility beyond the constraints of any Federal contract. We have been able to do many things — the data system is an example — because of your contributions. Our people can keep working when — and where — others cannot. We have the personnel, the skills, the experience, and the time to devote to many interests. Because of our linkages with national organizations, we are part of the information-sharing "grapevine" on issues of common interest.

With your continuing support, we will continue to represent you and your colleagues. We need you, and, if we may be so bold, you need us.

Nominations for Emeritus Membership

(Reference Committee "H")

The following nominations for election to emeritus membership have been received from the component societies. Conforming to the provisions of Article IV, Section 6, of the Constitution, all nominees are now and have

been members in good standing of a component society for at least twenty years, and by reason of age or infirmity have retired from the active practice of medicine. All are emeritus members of their respective component societies.

Atlantic County

Morton Major, M.D., Atlantic City; Age 68

Bergen County

Albert L. Higdon, M.D., Boca Raton, Fla. (formerly Teaneck); Age 59
C. Donald Lord, M.D., Mahwah Township; Age 69
N. Maurice Re, M.D., Alpine; Age 65

Camden County

Henry Steever Price, Jr., M.D., Marlton; Age 65

Essex County

Paul S. Andreson, M.D., Grand Junction, Colo. (formerly Elizabeth); Age 64
Edward Vincent Brown, M.D., S. Dennis, Mass. (formerly Caldwell); Age 76
Rachel Burstein, M.D., New York, N.Y. (formerly E. Orange); Age 64
Sidney Lazarus Cohen, M.D., Newark; Age 77
John Stoughton Cregard, M.D., Greenwood Lake, N.Y. (formerly E. Orange); Age 69
Allan Bernard Crunden, Jr., M.D., Montclair; Age 64
Louis Danzis, M.D., S. Orange; Age 70
James F. Foley, M.D., E. Orange; Age 71
Charles J. Grubin, M.D., Short Hills; Age 59
Albert G. Hulett, M.D., Orange; Age 86
Andrew Kallos, M.D., Kearny; Age 67
Robert M. Levinson, M.D., Orange; Age 75
Samuel Rosenbaum, M.D., W. Palm Beach, Fla. (formerly W. Orange); Age 65
Jerome C. Rothgesser, M.D., Washington, D.C. (formerly Newark); Age 65
Harriet N. Stein, M.D., E. Orange; Age 63
Irvin I. Taitz, M.D., New York, N.Y.; Age 66
George Urbach, M.D., Verona; Age 67
Charles A. Wallack, M.D., Westfield; Age 72

Hudson County

Samuel A. Cohen, M.D., Jersey City; Age 71
Vincent Justus Felitti, M.D., San Diego, Calif. (formerly North Bergen); Age 78
James J. Ortolano, M.D., Surf City; Age 69
Pasquale Anthony Statile, M.D., Hackensack; Age 63

Middlesex County

Abraham S. Shayeitz, M.D., South River; Age 69
Oscar J. Sokoloff, M.D., New Brunswick; Age 67

Morris County

Frederick A. Mettler, M.D., Blairstown; Age 69
Evelyn Louise Schumacher, M.D., Morris Plains; Age 65
D. Blair Sulouff, M.D., Morristown; Age 68

Ocean County

Charles Axinn, M.D., West Creek; Age 69
William X. Gebele, Jr., M.D., Cape Coral, Fla. (formerly Lakewood); Age 60

J. Bruce Henriksen, M.D., Brielle; Age 69
John J. Kloby, M.D., Seaside Heights; Age 67
C. Norman Witte, M.D., Point Pleasant; Age 69
Thomas M. Thompson, M.D., Bricktown; Age 67

Passaic County

F. Albert Graeter, M.D., Passaic; Age 67
Wayne W. Hall, M.D., Ridgewood; Age 79
H. Hale Hollingsworth, M.D., Ft. Myers, Fla.; Age 82
George Koerber, M.D., Clifton; Age 76
Allan W. MacGregor, M.D., Southbury, Conn.; Age 82
Louis Markowitz, M.D., Santa Fe, N.M. (formerly Pater-son); Age 77

Union County

Leo Burstein, M.D., Elizabeth; Age 67
Warren Dochterman, M.D., Basking Ridge; Age 65
Jean G. DuPuy, M.D., Elizabeth; Age 77
Carl Hanson, M.D., Cranford; Age 72
Joseph A. Lepree, M.D., Elizabeth; Age 69
Oscar Rozett, M.D., Summit; Age 67
Leonard D. Williams, M.D., Plainfield; Age 70

Approved (page Tr 133)

Supplemental Report #1

The following additional nominations for election to emeritus membership have been received:

Union County

C. Hartley Berry, M.D., Lake Wales, Florida (formerly Summit); Age 70
George L. Erdman, M.D., Summit; Age 67

Approved (page Tr 133)

Supplemental Report #2

The following additional nominations for election to emeritus membership have been received:

Passaic County

John E. Leach, M.D., Ridgewood; Age 68

Union County

Edward E. Feleppa, M.D., Summit; Age 70
James H. Maroney, M.D., Summit; Age 68

Approved (page Tr 133)

MEMORIAL RESOLUTION

The following resolution was received by the House with sorrowful concurrence.

John J. McGuire, M.D. (1909–1976)

Whereas, after a rich life of distinguished and exemplary service as a renowned physician and outstanding medical leader, John J. McGuire, M.D., our beloved President, suddenly has been called to his eternal reward; and

Whereas, in his years as a member, Doctor McGuire consistently rendered splendid service to The Medical Society of New Jersey as an officer and trustee; and

Whereas, in his medical practice he always exemplified the attributes of a true humanitarian and distinguished physician; and

Whereas, by his ever-present humor and wit he won the affection of all with whom he came in contact; now therefore be it

RESOLVED, that The Medical Society of New Jersey, honoring John J. McGuire in death as in life, records its profound grief at his passing; and be it further

RESOLVED, that a copy of this resolution be spread upon the minutes of this meeting; and be it further

RESOLVED, that this resolution be referred to the House of Delegates to be read at the opening session at the Annual Meeting; and be it further

RESOLVED, that another copy of this resolution, suitably prepared, be presented to his bereaved widow and family, in token of heartfelt sympathy.

RESOLUTIONS

#1

Admission of Osteopathic Physicians to The Medical Society of New Jersey

From the Union County Medical Society

(Reference Committee "A")

Whereas, it is the stated policy of the AMA, as per its 1967 House of Delegates, to encourage admission of osteopathic physicians into organized medicine; and

Whereas, the House of Delegates of The Medical Society of New Jersey in 1969 had endorsed these AMA principles and formed an ad hoc committee to investigate the possible admission of osteopathic physicians to The Medical Society of New Jersey; and

Whereas, the House of Delegates in 1970 did not act favorably on the recommendation of this committee because of the possible increase in malpractice insurance rates; and

Whereas, there is an increasing number of osteopathic school graduates who have enrolled in AMA-approved hospital internship and residency programs in the State of New Jersey; now therefore be it

RESOLVED, that The Medical Society of New

Jersey endorse the principle of accepting qualified osteopathic physicians into membership of our Society; and be it further

Foregoing "resolved" deleted upon recommendation of the Reference Committee.

RESOLVED, that the Board of Trustees form a committee to investigate the constitutional and actuarial consequences of admission of qualified osteopathic physicians into The Medical Society of New Jersey and to report to the House of Delegates at its next regular meeting.

Foregoing "Resolved" amended by the Reference Committee to read:

RESOLVED, that the Board of Trustees form a committee to investigate the practical and actuarial consequences of actively encouraging osteopathic physicians to join The Medical Society of New Jersey. The Committee shall report to the House of Delegates at its next regular meeting the advisability of accepting osteopathic physicians into the membership of The Medical Society of New Jersey.

Above "Resolved" further amended by the House to read:

RESOLVED, that the Board of Trustees form a committee to investigate the legal, practical, and actuarial consequences of admitting osteopathic physicians to join The Medical Society of New Jersey. The Committee shall report to the House of Delegates at its next regular meeting the advisability of accepting osteopathic physicians into membership of The Medical Society of New Jersey.

Adapted as amended by the House (page Tr 120)

#2

Assurance of Professional Competence

From the Camden County Medical Society

(Reference Committee "A")

Whereas, organized medicine is concerned with improving its image in the spheres of fee structure, malpractice irrationalities, and a multitude of onerous and poorly designed governmental regulations; and

Whereas, our national and state associations have oftentimes declared our dedication to the assiduous provision of high-quality medical care whenever and wherever needed; and

Whereas, the AMA and sundry component groups have episodically assailed the news media for their cyclical and slanted portrayal of medicine's shortcomings; and

Whereas, our leadership has been constantly placed in a defensive posture; and

Whereas, the saturation point of these efforts — and others — has probably been attained with only a modicum of salutary results; now therefore be it

RESOLVED, that The Medical Society of New Jersey be asked to embrace the following positions of intent, and if so endorsed, that the recommendations then be passed to the AMA House of Delegates for consideration and implementation during the Dallas Session in June 1976:

(1) That organized medicine ferret out situations of physician wrong-doing and pre-empt governmental and media investigations through affirmative disclosures of aberrant activity and a call for civil or criminal prosecution where indicated;

(2) That we shore up our grievance committee activities to mete out more severe penalties to those physicians who blatantly transgress the bounds of professional propriety, decency or competency;

(3) That we attempt to inculcate into all practitioners that should they willfully choose to become the bad apple in our art's barrel, then they should expect a lot no less than our scorn and rejection;

(4) Finally, let us resolve to give less consideration to the recertification for the overwhelming majority of our profession but rather, let us lend more impetus to the expulsion and delicensure of those in our ranks who would defame the good name of our honored profession.

Following substitute "Resolves" recommended by the Reference Committee:

RESOLVED, that The Medical Society of New Jersey emphasize the expulsion and delicensure of those physicians in our midst who would defame the good name of our honored profession; and be it further

RESOLVED, that this resolution be introduced, in suitable form, for adoption by the AMA House of Delegates at its Dallas, 1976 meeting.

Adopted as amended by the Reference Committee (page Tr 120)

#3

Samuel B. Mudd, M.D.

From the Union County Medical Society

(Reference Committee "A")

Whereas, a body of evidence exists that Samuel B. Mudd, M.D., the physician who treated John Wilkes Booth following the assassination of President Abraham Lincoln, was, in fact, innocent of the charge of conspiracy which resulted in his conviction and imprisonment; and

Whereas, a considerable body of evidence exists that Doctor Mudd acted in the best tradition of medicine when he gave medical treatment to one who was injured; and

Whereas, it is unconscionable that a doctor

should be imprisoned for giving such care; now therefore be it

RESOLVED, that The Medical Society of New Jersey petition the Legislature and the Governor of the State of New Jersey to request the President of the United States to issue a proclamation completely exonerating Doctor Mudd from participation in a conspiracy to take the life of Abraham Lincoln.

Not Adopted — see notation — (page Tr 121)

#4

Assignment of Benefits

From the Union County Medical Society

(Reference Committee "C")

Whereas, for many years, Medical-Surgical Plan of New Jersey has refused to honor patients' assignments which would allow their treating physicians to be paid directly by Medical-Surgical Plan of New Jersey; and

Whereas, the legal opinion justifying that refusal as in the public interest was based on the fact that at that time a majority of the physicians in each county had to be participating physicians with the Plan in order for it to be validated; and

Whereas, in 1964, via court action, that majority

ruling was negated and thereafter only a "reasonable number" of physicians were required to be participants with the Plan in order for it to be validated; now therefore be it

RESOLVED, that The Medical Society of New Jersey petition Medical-Surgical Plan of New Jersey to change its contract in order to allow assignment of benefits, and that The Medical Society of New Jersey petition the Commissioner of Insurance to honor this contract change.

Adopted (page Tr 123)

#5

Mandatory Payment of Professional Liability Assessment

From the Union County Medical Society

(Reference Committee "C")

Whereas, the House of Delegates, at its special meeting held on December 14, 1975, approved a \$200 per member voluntary assessment to support professional liability actions of The Medical Society of New Jersey; and

Whereas, this assessment could not be made compulsory until the regular annual meeting of the House of Delegates of The Medical Society of New Jersey; and

Whereas, such assessments should be compulsory for all members of The Medical Society of New Jersey; now therefore be it

RESOLVED, that this House of Delegates reapprove the \$200 assessment for this purpose making its payment mandatory for all regular dues-paying members.

Adopted (page Tr 123)

Resolution #6 was withdrawn by the sponsor before presentation to the House.

#7

Professional Liability Assessment

From the Board of Trustees

(Reference Committee "C")

Whereas, The Medical Society of New Jersey has formulated and is implementing a program to control professional liability; and

Whereas, in order effectively to do this, adequate financing is essential; and

Whereas, the House of Delegates at a Special Session in December 1975, approved a voluntary assessment for this purpose; and

Whereas, the assessment was voluntary by virtue of our current Constitution and Bylaws prohibiting mandatory assessments except at an annual meeting; and

Whereas, it is blatantly unfair for some physicians to benefit at the expense of others; now therefore be it

RESOLVED, that this House of Delegates hereby converts the voluntary assessment to a mandatory assessment of \$200 for the purpose of professional liability activity. This mandatory requirement does not apply to dues-exempt members. Members having paid the assessment prior to the Annual Meeting will be given appropriate credit.

Adopted (page Tr 123)

#8

Continuing Medical Education

From the Monmouth County Medical Society

(Reference Committee "D")

Whereas, the present program for continuing medical education, as proposed by The Medical Society of New Jersey, places the burden of proof and the burden of effort upon the compliant individuals; now therefore be it

RESOLVED, that the present program be dissolved and a new program be instituted wherein non-compliant individuals in the category of continuing medical education should assume the burden of paper work, time, and effort to establish compliance; and be it further

RESOLVED, that an attempt should be made automatically to channel to The Medical Society of New Jersey the compliance of an individual to the credit-hour requirements, especially in

category I, as well as hours automatically credited by hospitals at teaching events, i.e., medical rounds with house staff, and so on; and be it further

RESOLVED, that those whose names are automatically noted as non-compliants should be contacted personally by The Medical Society of New Jersey through the county society for rebuttal or acceptance to the status of non-compliance and an explanation of his status; and be it further

RESOLVED, that final judgment of compliance with or without reservation should be in the hands of peers at either county or hospital level.

Rejected (page Tr 124)

#9

Definition of Optometry

From the Monmouth County Medical Society

(Reference Committee "E")

Whereas, there has been legislation in other states designed to broaden the scope of optometry beyond its basic intent, abilities, and training; and

Whereas, an optometrist under New Jersey Statute is a limited non-medical practitioner with no qualifications to enter into the diagnosis

or treatment of disease; now therefore be it

RESOLVED, that The Medical Society of New Jersey is opposed to any legislation that would broaden the scope of the definition of optometry under New Jersey law.

Adopted (page Tr 127)

#10

Legislation Restricting the Use of Physician's Assistants Singling out One Particular Medical Specialty

From the Monmouth County Medical Society

(Reference Committee "E")

Whereas, there has been a trend in some states to restrict the use of assistants by ophthalmologists while permitting the use of physician's assistants to other physicians; now therefore be it

RESOLVED, that The Medical Society of New Jersey opposes any legislation which will restrict or interfere with the use of physician's assistants in any way that singles out one particular specialty.

Adopted (page Tr 127)

#11

Time Within Which a Minor's Suit Can Be Brought for Personal Injuries

From the Morris County Medical Society

(Reference Committee "E")

Whereas, in New Jersey, an adult has two years from the occurrence of a personal injury within which to bring a cause of action. Children, however, are treated as incompetents who cannot sue until they reach majority. This policy of protecting children by suspending the Statute of Limitations during their minority is very strong. In fact, as of 1966, all but three states in the country had such statutes; and

Whereas, on January 1, 1973, the New Jersey Legislature reduced the age of majority from twenty-one to eighteen, so that now an eighteen year old may sue. However, the Legislature specifically provided that children who were *both* under twenty-one and injured before the cut-off date of January 1, 1973, would be entitled to the protection of the old law, and have

until twenty-one plus two years to bring suit (N.J.S. 9:17B-3(e); N.J.S. 2A:14-21; N.J.S. 2A:14-2); and

Whereas, the statute is, therefore, prospective. For injuries sustained *after* January 1, 1973, the child now has until he is eighteen plus two years in which to sue, but for a pre-January 1, 1973, injury the child still has until he is twenty-one plus two to bring suit; now therefore be it

RESOLVED, that The Medical Society of New Jersey should request the Legislature to amend the date of January 1, 1973, as the cut-off point so that all cases prior to such date shall come under the same law.

Adopted (page Tr 127)

#12

Use of Drugs by Non-Medical Practitioners

From the Monmouth County Medical Society

(Reference Committee "E")

Whereas, there recently has been a trend in some states to permit the use of drugs by non-medical practitioners for "diagnostic purposes" as evidenced by legislation passed in Rhode Island and Pennsylvania; and

Whereas, it is against the public interest and welfare that non-medical practitioners be allowed to use drugs; now therefore be it

Jersey is opposed to any legislation that would allow the use of drugs of any type for diagnostic or other purposes by non-medical practitioners except under the direction of a licensed physician.

Reference committee amended the above by insertion of the word "eye" between the words "non-medical" and "practitioners" in the title and in lines 2, 7, and 12.

RESOLVED, that The Medical Society of New

Adopted as amended by the Reference Committee (page Tr 127)

#13

Medical Hypnosis in the State of New Jersey

From the Morris County Medical Society

(Reference Committee "F")

Whereas, by the action of the American Medical Association at the 107th Annual Meeting held in 1958, hypnosis was given official sanction as a medical therapeutic technique; and

Whereas, the American Medical Association Council on Mental Health did an exhaustive and a complete study on the subject; and

Whereas, the American Medical Association Council on Mental Health reached unanimous agreement as to the validity of various phenomena elicited by hypnotic techniques; now therefore be it

RESOLVED, that the Chairman of the Council on Mental Health and an officer of The Medical Society of New Jersey, in written letter to the administrator of each and every hospital in the State of New Jersey reaffirm the position of the American Medical Association concerning medical hypnosis as to the following:

(1) Recognize the importance of medical hypnosis as a valuable adjunct to the abilities of the practicing physician; and

(2) Request that the administrator act for change by encouraging the concept that hypnosis is of great value to general practitioners as well as the medical specialist with a background in psychodynamic psychology and psychiatry; and be it further

Reference Committee amended foregoing paragraph (2) to read:

(2) Request that the administrator act for change by encouraging the concept that hypnosis is of value to general practitioners as well as the medical specialist with a background in medical psychopathology; and be it further

Adopted (page Tr 129)

RESOLVED, that the Chairman of the Council of Mental Health and an officer of The Medical Society of New Jersey in written letter to the presidents of the New Jersey Medical and Dental Schools, urge that teaching related to hypnosis be encouraged, not only for students but also in the form of postgraduate courses; with emphasis on the indications and limitations of hypnosis.

Adopted as amended by Reference Committee (page Tr 129)

#14

Creation of a Special Committee on Hearing and Speech

From the Mercer County Medical Society

(Reference Committee "G")

Whereas, the Special Committee on the Conservation of Vision, Hearing, and Speech of The Medical Society of New Jersey serves the functions of two specialties which are no longer related; and

Whereas, the conservation of hearing is no longer the only concern of the otolaryngologist; now therefore be it

RESOLVED, that a new committee be created to serve the specialty of otolaryngology and thus separate the Special Committee on the Conservation of Vision, Hearing, and Speech; the conservation of hearing to become one of the functions of a new committee with its own chairman, that Committee to be that of Conservation of Hearing and Speech.

Adopted (page Tr 131)

#15

Commendation to Arthur Bernstein, M.D.

From the Board of Trustees

(Reference Committee "H")

RESOLVED, that the House of Delegates of The Medical Society of New Jersey recognizes and commends the outstanding service rendered to the annual meetings of this Society by Arthur Bernstein, M.D., during his tenure on the Sub-

committee on Scientific Exhibits, the Subcommittee on Scientific Sessions, and the Committee on Annual Meeting.

Adopted by acclamation (page Tr 133)

#16

Return Annual Meeting to Atlantic City

From the Hudson County Medical Society

(Reference Committee "H")

Whereas, The Medical Society of New Jersey enjoyed the atmosphere and facilities of Atlantic City as the site of the annual meeting for many years; and

the foreseeable future because of inadequate space and facilities in the Cherry Hill area; now therefore be it

Whereas, the facilities at Cherry Hill produced many problems due to a lack of sufficient space for meetings, exhibits, and housing; and

RESOLVED, that the annual meeting be returned to Atlantic City at the earliest possible date.

Whereas, there will continue to be difficulties for

Referred to Committee on Annual Meeting, by action of the House (page Tr 133)

#17

Teenage Alcoholism

From the Essex County Medical Society

(Reference Committee "F")

Whereas, a resolution from New Jersey recently adopted by the American Academy of Family Physicians attested to the volume and dramatic increase in teenage alcoholism; and

Whereas, it is apparent to the practicing physician that this problem is on the upswing; and

Whereas, easy access to alcohol makes this a far

greater problem than other forms of drug abuse; and

Whereas, routine health education in school grades 7-12 should emphasize the deleterious effects and addicting potential of alcohol; now therefore be it

Jersey bring to the attention of the State Legislature and the Governor the necessity for early routine health education in the schools on the prevention of alcoholism.

Foregoing "Resolved" amended by the House by insertion of the words "and the State Department of Education" after the word "Governor" in line 3.

RESOLVED, that The Medical Society of New

Adapted as amended by the House (page Tr 130)

#18

CME Requirement

From the Essex County Medical Society

(Reference Committee "D")

Whereas, The Medical Society of New Jersey's three-year period for reporting 150 post-graduate hours of credit will end in June 1976; and

Whereas, this has created a backlog and some applications for the Award submitted last November still have not been processed; now therefore be it

Whereas, the recommended method for reporting these required credits was by attaining the AMA Physician's Recognition Award; and

RESOLVED, that The Medical Society of New Jersey declare a one-year extension or make-up period during which all members must attain the AMA Physician's Recognition Award unless specifically exempted from same due to illness.

Whereas, over 11,000 applications were recently received by the AMA in a two-month period; and

Rejected (page Tr 125)

#19

Health and Nutrition Program for New Jersey Schools

From the Essex County Medical Society

(Reference Committee "G")

Whereas, hypertension is highly prevalent in the American population and is influenced by nutrition; and

Whereas, obesity is the most prevalent form of malnutrition presently in the American population; and

Whereas, dental caries is rampant and greatly influenced by diet; and

Whereas, the teaching of health and nutrition in our public and parochial schools is highly inadequate and contains obsolete concepts; and

Whereas, school vending machines offer junk foods; and

Whereas, the planning of school menus should be done by personnel trained in up-to-date

dietary concepts; now therefore be it

RESOLVED, that The Medical Society of New Jersey offer an advisory committee of physicians knowledgeable in health education and nutrition to the New Jersey Department of Education for the purpose of formulating and implementing an integrated health and nutrition educational program for all New Jersey schools.

Adopted with notation (page Tr 131)

#20

Involuntary Commitment

From the Essex County Medical Society

(Reference Committee "E")

Whereas, psychiatry is a specialty of medicine and all of its practitioners are physicians with all the rights and privileges thereof; and

Whereas, a full understanding of mental illness requires a knowledge of the relationship between the functioning of mind and body; and

Whereas, many physical illnesses may present themselves with psychiatric symptoms and similarly mental problems may present themselves with physical symptoms; and

Whereas, all physicians have basic knowledge of and training in psychiatry especially in regard to acute psychiatric problems; and

Whereas, psychiatric hospitals or units are medical facilities; now therefore be it

RESOLVED, that The Medical Society of New Jersey strongly recommends that there be no change in the present laws regarding involuntary psychiatric commitment, which laws now permit all licensed physicians to sign the necessary commitment forms; and be it further

RESOLVED, that The Medical Society of New Jersey actively oppose any legislation which would permit non-medically trained psychologists to perform this function.

Adopted (page Tr 127)

#21

Program of Minimal Primary and Secondary Prevention

From the Essex County Medical Society

(Reference Committee "G")

Whereas, treatment of established disease is often costly; and

Whereas, primary (risk factor modification) and secondary (early intervention) prevention are highly desirable for the public; and

Whereas, only a few diseases actually can be prevented by primary and secondary means; now therefore be it

RESOLVED, that The Medical Society of New Jersey endorse the following minimal 10-point program for primary and secondary prevention, a program that should be followed by each adult in the community on his or her own volition:

1. Women — Pap smear over age 30, every two years — more often with suspicious findings on last Pap.

2. Women over age 35 — yearly breast examination by M.D. Self-examination once a month. Xerography or mammography every two years is optional.

3. All over age 40 — yearly hemoccult test for blood in stools.

4. Blood pressure determination every two years.

5. Blood cholesterol level every two years unless previously elevated; if borderline or elevated, reduce with diet and a check every year.

6. Over age 35 — eye examination every three years including tonometry for intraocular pressure.

7. All occupants in automobiles should wear seat belts and all children should be restrained.

8. Cigarettes, if used — maximum number daily should not exceed 10, preferably no more than 5/day and ideally none. Stop entirely with chronic cough.

9. Check for anemia (hemoglobin) every two years.

10. Men — prostate examination every three years after age 49.

Referred to Council on Public Health (page Tr 131)

#22

Social Security Number of either the Physician or Patient as a Universal Numbering Identifier

From the Essex County Medical Society

(Reference Committee "F")

Whereas, in 1934, the Social Security Act was created as a social insurance vehicle; and

Whereas, a numbering identifier was assigned to every covered insured; and

Whereas, there are federal regulations specifying that the Social Security number may be required only for Social Security Administration and Internal Revenue Service purposes with all other uses being voluntary; and

Whereas, we are now being informed by the Department of Health, Education and Welfare that they are mandating the use of such Social Security number of either the physician or patient as an identifier on all hospital records in order to enable the Bureau of Quality Assurance to tie medical records to an individual physician; and

Whereas, the use of Social Security number is being considered as mandatory for implementation of data collection procedures in the Professional Standards Review Organization Act; and

Whereas, other national number identifiers such as the AMA inquiry card or AMA continuing medical education number might be utilized or a separate number system worked out which would be satisfactory to all; now therefore be it

RESOLVED, that The Medical Society of New Jersey herewith expresses its total opposition to

the use of the Social Security number of either the physician or patient as a universal numbering identifier; and be it further

RESOLVED, that the use of a Social Security number be specifically prohibited in the data collection process for peer review, except as voluntarily accepted; and be it further

RESOLVED, that the AMA be requested to develop a physician identifier which would satisfy federal requirements and retain needed confidentiality; and be it further

RESOLVED, that this resolution be directed to the AMA, the United States Department of Health, Education, and Welfare, the New Jersey Congressional Delegation, the New Jersey Medicare and Medicaid and Maternal and Child Health intermediaries, and other interested parties for their information.

Adapted (page Tr 130)

#23 High Fees for Participation in Continuing Medical Education Programs

From the Monmouth County Medical Society
(Reference Committee "D")

Whereas, regular participation in programs of continuing medical education is now required of all members; and

Whereas, fees for attendance at some programs have become excessively costly; and

Whereas, it has always been the duty of a physician to teach his art to his fellow physician without profit; now therefore be it

RESOLVED, that The Medical Society of New

Jersey is opposed to charging a participant a fee in excess of the actual cost of providing the educational program.

With approval of the sponsor, Reference Committee amended the foregoing "resolved" and included two additional "resolveds," to read:

RESOLVED, that The Medical Society of New Jersey is opposed to charging a participant a fee in excess of the reasonable cost of providing the educational program; and be it further

RESOLVED, that the sponsoring agency be required to indicate whether it is a profit or non-profit educational endeavor; and be it further

RESOLVED, that the New Jersey Delegation to the AMA be instructed to introduce the above resolution at the AMA meeting in Dallas.

Adapted as amended by the Reference Committee (page Tr 125)

#24 Blue Shield Claim Form

From the Passaic County Medical Society
(Reference Committee "C")

Whereas, the Blue Shield claim form is the most confusing and complicated in the industry, subject to error on the part of the subscriber and on the part of the physician; and

Whereas, Blue Shield alone among the major health insurance carriers in this state refuses to accept a copy of a thoroughly itemized bill as a description of services and charges; and

Whereas, Blue Shield alone among the major health insurance carriers in this state refuses to accept the standardized Health Insurance Council form; and

Whereas, Blue Shield requires the physician to make statements regarding matters such as cause and injury, co-insurance, and so on, which can be based only upon hearsay; and

Whereas, the doctor is required to keep on hand the number of different Blue Shield forms which merely adds to the confusion and increases the likelihood of error; and

Whereas, in the case of a non-participating physician the contract for health insurance is between the patient and his carrier; and

Whereas, the increasing volume of paperwork is driving up the cost of medical care; now therefore be it

RESOLVED, that The Medical Society of New Jersey has determined that a physician fulfills his obligation to his patients by [affixing an itemized bill to the insurance form, or by] submitting a standard Health Insurance Council form; and be it further

RESOLVED, that Medical-Surgical Plan be requested to accept the above [in lieu of the use of separate claim forms].

Foregoing "Resolveds" amended by the House by deletion of "affixing an itemized bill to the insurance form, or by" in the first "Resolved" and "in lieu of the use of separate claim forms" in the second "Resolved."

Adopted as amended by the House (Page Tr 124)

House accepted decision of Committee on Resolutions that Resolutions #25, #26, and #27 were deemed not properly emergency resolutions.

#28

Exemptions from Continuing Medical Education Requirements

From the Union County Medical Society

(Reference Committee "D")

Whereas, the House of Delegates approved the recommendation of the Ad Hoc Committee on Continuing Medical Education in 1972, and revised the sections of the Constitution of The Medical Society of New Jersey in 1972 and 1973 to require 150 hours of continuing medical education for membership in MSNJ; and

Whereas, there have been continued and repeated announcements at MSNJ meetings, component county society meetings, membership newsletters, county bulletins, and *The Journal* of MSNJ advising all members of these requirements; and

Whereas, there was never any mention in any of these announcements that certain physicians in administrative positions and physicians who

were employees of governmental agencies or third party payers would be excused from these obligations; and

Whereas, the concept of two classes of citizenship is abhorrent to all members of this House of Delegates; now therefore be it

RESOLVED, that the actions taken by the Board of Trustees of MSNJ, as published in the *Membership Newsletter* No. 248 (April, May 1976) "Guidelines for Exemptions from Continuing Medical Education," paragraph (e) — wherein such members are to be granted a three-year extension — be abrogated by this House of Delegates and that exemptions for reasons other than poor health, age, or infirmity be denied.

Adopted (page Tr 125)

House accepted decision of Committee on Resolutions that Resolution #29 was deemed not properly an emergency resolution.

#30

Physician Employment and Utilization of Ancillary Personnel and/or Physicians' Assistants

From the Board of Trustees

(Reference Committee "E")

Whereas, the House of Delegates of The Medical Society of New Jersey has, at various times, approved in principle legal authorization for physicians to employ and utilize ancillary

personnel and physicians' assistants; and

Whereas, the Council on Legislation and the House of Delegates have consistently opposed

legislation no matter how phrased, to effect what be it further
has been adopted in principle; and

Whereas, the Board of Trustees and the staff find themselves in a consistently unsupportable position; now therefore be it
RESOLVED, that the position of the House be implemented through definitive action on S-831 and S-1354 of 1976.

RESOLVED, that the House of Delegates take a firm and positive position on the use of ancillary personnel and physicians' assistants; and

Foregoing "Resolved" amended by the House to read:

RESOLVED, that the position of the House be implemented through definitive action on S-831 and S-1354 of 1976, and that this definitive action be ACTIVE OPPOSITION to these bills.

Adopted as amended by the House (page Tr 127)

#31

Support for an Appropriate Swine Influenza Immunization Program

From the Mercer County Medical Society

(Reference Committee "G")

Whereas, a strain of influenza virus similar to the one causing the pandemic of 1918 apparently exists in the population; and

support during the polio vaccination many years ago created a favorable public image for us; now therefore be it

Whereas, an influenza pandemic caused by this virus (New Jersey or swine) is a possibility this Fall; and

RESOLVED, that The Medical Society of New Jersey House of Delegates go on record as expressing an attitude of support for an appropriate influenza vaccination program which, we believe, would be in the public's best interest and that a copy of this resolution be forwarded to the appropriate public health authorities and the news media.

Whereas, the President of the United States and the Surgeon General have expressed a feeling of necessity for a generalized influenza vaccination program; and

Whereas, the medical professions' attitude of

Adopted (page Tr 131)

House accepted decision of Committee on Resolutions that Resolutions #32 and #33 were deemed not properly emergency resolutions.

#34

Cancer Prevention

From the Hudson County Medical Society

(Reference Committee "G")

Whereas, recently published findings of a national health organization indicate that the incidence of many deadly forms of cancer in New Jersey is well above that for the nation as a whole; and

Whereas, while ranking eighth among the states in population, New Jersey has been found to be first in the number of reported cases of lung, breast, bladder, intestinal, and rectal cancer; and

Whereas, many scientific studies have suggested that environmental factors such as air and water pollution and occupational exposure to potential carcinogens are responsible for recent increases in the cancer mortality rate; and

Whereas, to the extent that such environmental factors are or may be within the control of public authorities, it is incumbent upon the governmental authorities of the State of New Jersey to ascertain the actual need and possible methods of exercising such control; and

Whereas, the Senate of the State of New Jersey has created a "Commission on Incidence of

Cancer in New Jersey" whose duties are to study reasons for the extraordinary incidence of cancer in New Jersey and report findings and recommendations to the Senate with accompanying legislative bills; now therefore be it

RESOLVED, that The Medical Society of New Jersey strongly urge that the full weight of governmental, medical, industrial, and public expertise be quickly brought to bear on this problem; and be it further

RESOLVED, that sufficient funding be obtained and expert staff organized in order that appropriate legislation and regulations be quickly developed which will decrease the horrendous rate of cancer in people of this State.

Reference Committee recommended that the foregoing "Resolves" be amended to read:

RESOLVED, that The Medical Society of New Jersey strongly urge that the full weight of governmental, medical, industrial and public expertise be quickly brought to bear on the problem of cancer in the State of New Jersey; and be it further

RESOLVED, that sufficient funding be obtained and expert staff organized in order that appropriate legislation and regulations quickly be developed in consultation with the Medical Society of New Jersey in an attempt to decrease the horrendous rate of cancer in people of this State.

Adapted as amended by Reference Committee (page Tr 132)

House accepted decision of Committee on Resolutions that Resolution #35 was deemed not properly an emergency resolution.

#36 Actively Oppose S-889

From Robert E. Jennings, M.D., Delegate, Essex County
(Reference Committee "E")

Whereas, prior to passage of the 1974 Child Abuse Law, physicians were required to report suspected cases of child abuse directly to prosecutors; and

Whereas, the 1974 law properly changed this reporting mandate so that physicians now must report suspected cases to a social service agency, namely, the Division of Youth and Family Services; and

Whereas, there has been a dramatic increase in the number of cases reported since the Division of Youth and Family Services was designated the agency to which reports are made; and

Whereas, as Senate Bill 889 mandates that we revert to the previous method of reporting cases of child abuse to the prosecutor's office; and

Whereas, it is generally recognized that the families of these children need considerable supportive help as presently is provided in the reporting system to the Division of Youth and Family Services; now therefore be it

RESOLVED, that The Medical Society of New Jersey actively oppose S-889 so that all suspected cases of child abuse are to be properly reported to the Division of Youth and Family Services as mandated in the 1974 law; and be it further

RESOLVED, that The Medical Society of New Jersey make this active opposition known to all members of the Institutions, Health and Welfare Committee of the New Jersey Assembly.

Adopted (page Tr 127)

House accepted decision of Committee on Resolutions that Resolutions #37, #38, and #39 were deemed not properly emergency resolutions.

#40

Atomic Energy Plants

Harvey J. Shwed, M.D., Delegate, Essex County
(Reference Committee "G")

Whereas, physicians have fought the scourges of mankind; namely, the epidemic diseases, with some degree of success; and

Whereas, the thrust of medical efforts is increasingly toward the prevention of ill health and to the enhancement of good health and to the development of full potential of all human beings; and

Whereas, the utilization of nuclear energy, the proliferation of atomic plants, expose the entire population to carcinogenic and mutagenic hazards through:

1. radiation pollution of land, water, and air;
2. the deliberate development of a man-made toxin for the Breeder Reactor, i.e., perilous plutonium;
3. occupational radiation exposure in mining uranium ore and working within atomic plants;
4. the unsolved, horrendous problem of disposal and guarding death-dealing radioactive wastes; and

Whereas, our experience indicates that the allowable level of radiation exposure has been repeatedly reduced as its toxicity and long-range harmful effects have become evident; and

Whereas, there are practical alternative solutions to supply our energy needs; namely

1. a full-scale energy efficiency program;
2. a prompt and earnest energy conservation program;
3. the use of solar, wind, geothermal and other sources of energy which are abundant, accessible and far less polluting and make us independent of unreliable foreign sources; now therefore be it

RESOLVED, that The Medical Society of New Jersey vigorously support

1. an immediate moratorium on the building of atomic energy plants;
2. the implementation of means to utilize clean alternative sources of energy; and
3. forceful programs of energy efficiency and energy conservation.

Reference Committee recommended that foregoing "Resolved" section be amended to read:

RESOLVED, that The Medical Society of New Jersey vigorously support

1. further study of the health implications of an atomic energy plant off the coast of New Jersey, and that

2. a committee of selected physicians be appointed (by the Board of Trustees) for the urgent task of meeting with the scientists of the appropriate nuclear energy commission as soon as possible and that their findings be reported to the 1977 House of Delegates of The Medical Society of New Jersey.

Adopted as amended by the Reference Committee (Page Tr 132)

#41

Serology Testing and Health

From the Ocean County Medical Society

(Reference Committee "G")

Whereas, the State Department of Health has discontinued free testing for syphilis and rubella, and plans to start charging a fee for these tests; and

Whereas, this action will inevitably result in fewer tests being performed, and much poorer reporting of test results; and

Whereas, there surely will follow an increase in undiscovered and untreated syphilis with its attendant complications — paresis and dementia, with a larger custodial cost, as well as personal human suffering; and

Whereas, this action was taken without public discussion, and apparently in disregard of the public health; and

Whereas, there is nothing to indicate that the monies theoretically saved have been allocated to any equally necessary service; now therefore be it

Jersey deplores this action by the State Department of Health; and be it further

RESOLVED, that The Medical Society of New Jersey requests the Governor permanently to enjoin the Department of Health from this action; and be it further

RESOLVED, that a fully itemized and detailed certified public accounting of the disbursement of the budget of the State Department of Health immediately be prepared for the past three years, and proposed for next year, and published so that the people may determine for themselves the wisdom of the cost containment efforts of that Department; and be it further

RESOLVED, that the Board of Trustees of The Medical Society of New Jersey be directed to institute suit against the Department of Health, should such action be necessary to ensure the health of the public.

RESOLVED, that The Medical Society of New

Not Adopted (page Tr 132)

REFERENCE COMMITTEES

Reference Committee on Constitution and Bylaws

Frank Y. Watson, M.D., Chairman

Reference Committee on Constitution and Bylaws met on Saturday, June 5, 1976, with the following members present: Doctors Thaddeus Balinski, Richard B. Berlin, Robert S. Rigolosi, Salvatore J. Angelo, and the chairman. Approximately 20 delegates and members were present to discuss the various items under consideration.

This report deals with:

1. A proposed comprehensive change in the Constitution and Bylaws to take effect at the end of the meeting of the House of Delegates in 1977 (Exhibit #1). Implicit in this proposed change in the Constitution are changes in the Bylaws to be proposed to the House of Delegates in 1977.

2. Proposed changes in the current Constitution (Second Year reading) that if adopted today will become effective at the close of this annual meeting of the House of Delegates and which will be incorporated into the new Constitution and Bylaws as Bylaws next year. (See Exhibits #2 and #3)

3. Proposed changes in the current Bylaws that, if adopted today, will become effective at the close of this annual meeting of the House of Delegates and that will be included in the comprehensive revision of the Constitution and Bylaws that will be presented to the House of Delegates at the 1977 annual meeting.

The present Constitution and Bylaws provide that proposed amendments to the Constitution after due notice to the component societies must be read and approved by majority vote at one annual meeting and then after due notice to all members read again and approved by 2/3 majority vote at the next annual meeting of the House of Delegates. This procedure requires approximately fourteen months to effect a change in the Constitution.

The proposed Constitution is a concise statement of the Purposes of The Medical Society of New Jersey and of the composition (membership) and of the broad organizational structure of MSNJ.

The new Bylaws to be proposed in 1977 will utilize those portions of the present Constitution which are deemed to be more properly Bylaws, will prescribe how the Society functions, and will include all rules and procedures that the House of Delegates considers essential for the accomplishment of the purposes, for the maintenance of its composition, and for the ongoing operation of the Society.

The Constitution as proposed in Exhibit 1 and the Bylaws to be proposed in 1977 will be complementary and will form a complete and up-to-date document that will retain the essential and desirable components of the present Constitution and Bylaws and will include modern and desirable rules and procedures that strengthen the democratic process and provide for a more efficient and dynamic operation of the Society that will enable it to meet the ever-increasing challenges facing it today.

Revision of Constitution and Bylaws (page Tr 47)

a. Constitution

(1) First Year

Proposed Constitution to The Medical Society of New Jersey (page Tr 48)

The Committee recommends the following amendment to the proposed Constitution which appears on page Tr 48.

Article IV — Members

This Society is composed of individual members of component societies *who are entitled to*

full privileges and others as provided in the By-laws.

Adopted

The Committee **recommends** first year adoption of the proposed Constitution as amended by the Reference Committee.

Adopted

(2) Second Year

(a) Article IX — Officers, Section 1 — Terms of Office (page Tr 47)

This item was accepted by the House of Delegates last year. Adoption requires a two-thirds majority vote. The Committee on Revision of Constitution and Bylaws found this item desirable and recommended the amendment concerned with the terms of office of MSNJ officers be adopted (Exhibit 2, page Tr 49).

The Reference Committee **recommends** adoption of the proposed Constitutional amendment to Article IX — Officers, Section 1 — Term of Office.

Adopted

(b) Article XII — Amendments to the Constitution (pages Tr 47, 49)

This proposal was accepted by the House of Delegates last year. Adoption requires a two-thirds majority vote. The Committee on Revision of Constitution and Bylaws found it desirable and recommended its adoption.

The Reference Committee believes that the language dealing with amendment at a special session (paragraph 1 of Exhibit 3) is inappropriate. In discussion with Mr. Maressa and Dr. D'Elia and review of the minutes of the Standing Committee on Revision of Constitution and Bylaws, it has been presented that the phrase referring to the special session was inadvertently incorporated in this proposal and was not intentionally put therein.

Therefore, the Reference Committee **recommends** that the portion be deleted and that the

language before the House in this section terminate with the words annual meeting, as follows:

1. Submission in writing of an amendment proposed by the Board of Trustees, by the Judicial Council, or by a component society to the Secretary of this Society not later than December 31 of the year prior to the annual meeting.

Adopted as amended by the Reference Committee.

In discussing paragraph 2 of Article XII, the Committee felt that the time within which notice is to be given should be clearly specified. This would be accomplished by inserting the words "within ten (10) days" following the word transmission, as follows:

2. Transmission, within ten (10) days, by the Secretary, of the proposed amendment to the Standing Committee on Revision of Constitution and Bylaws and to each component society.

The Committee **recommends** that the suggested revision in paragraph 2 of the proposed amendments to Article XII — Amendments to the Constitution, be adopted.

Adopted

The Committee **recommends** second year adoption of Article XII of the Constitution as proposed and amended.

Adopted

b. Bylaws

(1) Chapter IV — House of Delegates, Section 1 — Meetings (pages Tr 47, 50)

The Committee on Revision of Constitution and Bylaws found this change desirable and urges its enactment.

The Reference Committee fully concurs that most meetings of the House of Delegates should be open and believes that the most desirable way to attain this is to have the House declare its meetings open sessions at the beginning of each

meeting rather than providing in the Bylaws that all meetings are open except when the House chooses to meet in closed session.

The Reference Committee views the matter not as a choice between open or closed meetings, but rather as a choice between the adverse psychological impact and adverse publicity that would occur if the House simply chooses not to declare a particular session an open session versus the House declaring that a particular meeting or session is to be closed.

The Reference Committee admits that the choice is a subtle one, but has "bitten the bullet" and **recommends** that this proposed amendment be not adopted.

Adopted

(2) Chapter V — Procedure of Election, Section 1 — Nominating Committee (pages Tr 47, 50)

The Committee on Revision of Constitution and Bylaws indicated that in its opinion this proposed change in the Bylaws would provide a more democratic and knowledgeable format for election to MSNJ posts and also would assure a more open functioning of the electoral process. That Committee recommended that the proposed change be adopted. The Reference Committee concurs and wishes to emphasize that the recommended limitation on the term of office of nominating delegates is applying to the nominating delegates only the principle of limitation of term of office that has already been recommended for the terms of office for officers, the elected trustees, secretary, treasurer, and members of the Judicial Council.

This concept is applied also to the standing committees of the Society and has been for a number of years.

This will have the additional desirable effect of broadening the involvement of an increased number of members in the essential democratic activities of the Society.

The Reference Committee believes that the words italicized in paragraph (1) — which follows — are redundant and that their deletion

would not change the meaning of the proposed amendment.

(a) Each component society shall elect at any meeting prior to March 31 of the fiscal year, one of its *elected* delegates to serve as a member of the Nominating Committee. At the same time, each component society shall elect one of its *elected* delegates to serve as the alternate member of the Nominating Committee. Nominating delegates shall serve only one *elected* three-year term. They may, in addition, serve a maximum of two years of an unexpired term.

The Committee **recommends** that the amendment be adopted and that the italicized words be deleted from Chapter V — Procedure of Election, Section 1 — Nominating Committee.

Not adopted

The Reference Committee also believes the changes indicated below in proposed paragraph (d) of Section 1 are only editorial in nature and clarify the proposal without changing its meaning.

(d) The *nominating* delegates, *or their* alternates, and the representative of the Fellows shall *comprise* the Nominating Committee. The Committee shall be required to meet at least forty (40) days prior to the opening session of the *Annual Meeting of the House of Delegates*. Its [written] report of nominations for the offices being filled shall be mailed with the advance material to the delegates and shall be printed in the Membership Newsletter and The Journal prior to the Annual Meeting. (Italics indicate amendment by inclusion, bracket indicates deletion.)

The Committee **recommends** that the editorial amendments to paragraph (d) of Section 1 be adopted.

Adopted

The Committee **recommends** that Chapter V, Section 1 (d) be adopted as amended by the Reference Committee.

Adopted

The Reference Committee feels that the proposal that the Nominating Committee meeting be conducted in accordance with *Sturgis' Standard Code of Parliamentary Procedure*, as described in section 2 (c), is most desirable and long overdue because it will require of that meeting for the first time the same high standard of parliamentary procedure to which the House of Delegates, the Board of Trustees, and the various other committees and councils of this Society have long conformed.

The Reference Committee also feels that the proposed requirement that a curriculum vitae of a candidate must be available to the Nominating Committee is just good common sense because it is obvious that without such information no nominating committee could make an informed choice among proposed candidates.

The Committee **recommends** that Chapter V, Section 2 (c) of the Bylaws be adopted.

Adopted

(3) Chapter XI — Component Societies, Section 2 — Qualifications of Members (page Tr 48)

This proposal would delete the requirement of citizenship or declaration thereof from the Bylaws. The Board of Trustees and the Committee on Revision of Constitution and Bylaws favors its adoption and recommends that the Bylaw change in Exhibit #6 (page Tr 52) be adopted.

The Reference Committee on Constitution and Bylaws concurs in this recommendation for two reasons. First, the Committee feels such a requirement is inappropriate for membership in MSNJ. Second, similar provisions in all state licensing laws have been declared unconstitutional by the United States Supreme Court.

The Committee **recommends** that the Bylaw change proposed in Exhibit #6 (page Tr 52) be adopted.

Adopted

Reference Committee "A"

Karl T. Franzoni, M.D., Chairman

Reference Committee "A" met on Saturday, June 5, 1976, with all members present: Doctors Warren H. Knauer, Thomas E. Mattingly, Jr., Frank A. Wolf, Robert B. Ambrose, Frank B. Doggett, Jr. (alternate), and the chairman. Approximately 50 delegates and members were present to discuss the various items under consideration.

1. President (page Tr 5)

The Committee **recommends** that the report be filed.

Adopted

2. Board of Trustees (page Tr 17)

The introductory portion of this report, covering the general activities of the Board, was reviewed and approved.

The Committee **recommends** that the report be filed.

Adopted

a. Eighth AMA Delegate and Alternate Delegate (page Tr 17)

The committee **recommends** that the report be filed.

Adopted

b. Invited Guests (page Tr 17)

The Committee **recommends** that the report be filed.

Adopted

c. Policy Statement on Support of Litigation Instituted by Specialty Societies (page Tr 17)

The Committee **recommends** that the report be filed.

Adopted

d. Joint Practice Committee with the New Jersey State Nurses' Association (Supplemental #1) (page Tr 22)

The Committee **recommends** that the report be filed.

Adopted

3. Secretary (page Tr 8)

The Committee **recommends** that the report be filed.

Adopted

4. Judicial Council (page Tr 24)

The Committee **recommends** that the report be filed.

Adopted

5. Executive Director (page Tr 25)

The Committee **recommends** that the report be filed.

Adopted

6. Credentials (page Tr 27)

The Committee **recommends** that the report be filed.

Adopted

7. Special Committee on Long Range Planning and Development (page Tr 80)

The Committee **recommends** that the report be filed.

Adopted

8. Resolutions:

(a) Admission of Osteopathic Physicians to The Medical Society of New Jersey — Resolution #1 (page Tr 97)

The Committee **recommends** that the first "resolved" portion of Resolution #1 be deleted and that the second "resolved" be amended to read as follows:

RESOLVED, that the Board of Trustees form a committee to investigate the practical and actuarial consequences of actively encouraging osteopathic physicians to join The Medical Society of New Jersey. The Committee shall report to the House of Delegates at its next regular meeting the advisability of accepting osteopathic physicians into the membership of The Medical Society of New Jersey.

The Committee **recommends** that Resolution #1, be adopted, as amended.

The above "Resolved" was further amended by the House to read:

RESOLVED, that the Board of Trustees form a committee to investigate the legal, practical, and actuarial consequences of admitting osteopathic physicians to join The Medical Society of New Jersey. The Committee shall report to the House of Delegates at its next regular meeting the advisability of accepting osteopathic physicians into the membership of The Medical Society of New Jersey.

Adopted as amended by the House.

(b) Assurance of Professional Competence — Resolution #2 (page Tr 97)

The Reference Committee agreed with the concept expressed in Resolution #2, but not with the language contained in the "resolved" portions.

The Committee **recommends** that the following substitute "resolveds" be adopted:

RESOLVED, that The Medical Society of New Jersey emphasize the expulsion and delicensure of those physicians in our midst who would

defame the good name of our honored profession; and be it further

RESOLVED, that this resolution be introduced, in suitable form, for adoption by the AMA House of Delegates at its Dallas, 1976 meeting.

The Committee **recommends** that Resolution #2 be adopted as amended.

Adopted

(c) **Samuel B. Mudd, M.D.** — Resolution #3 (page Tr 98)

The Reference Committee **recommends** that Resolution #3 be not adopted because The Medical Society of New Jersey is not in a position to attest to the innocence or guilt of Dr. Mudd in relationship to the Lincoln assassination.

Adopted

Reference Committee "B"

Raymond A. McCormack, Jr., M.D., Chairman

Reference Committee "B" met on Saturday, June 5, 1976, with the following members present: Doctors Victor H. Boogdanian, James E. Brennan, Edward M. Coe, Donald A. McLean, and the chairman. Approximately 24 delegates and members were present to discuss the various items under consideration.

1. Treasurer (page Tr 9)

The Committee **recommends** that the report be filed with special appreciation expressed to Dr. Rudolph Gering for a job well done.

Adopted

2. Finance and Budget (page Tr 28)

The Committee **recommends** that the recommendations on pages Tr 29, 30 of the annual report be approved.

Adopted

The Committee **recommends** that the report of the Committee on Finance and Budget be filed.

Adopted

3. Medical Student Loan Fund (page Tr 43)

The Committee **recommends** that the recommendations on page Tr 46 of the annual report be approved.

Adopted

The Committee **recommends** that the report of the Committee on Medical Student Loan Fund be filed.

Adopted

4. Physicians' Relief Fund (page Tr 83)

The Committee **recommends** that the recommendations contained in the report on Physicians' Relief Fund be approved.

Adopted

The Committee **recommends** that the report be filed.

Adopted

5. Publication (page Tr 46)

The Committee expressed pride and appreciation for the quality of *The Journal*, MSNJ.

The Committee **recommends** that the report be filed.

Adopted

The Committee wishes to thank Mr. Lambert, Dr. Ornaf, Dr. Greifinger, Dr. Kline, Dr. Roth, and Dr. O'Regan for their availability to the Committee and their informational assistance.

The availability of annual reports of the New Jersey Foundation for Health Care Evaluation and the Statewide PSRO Support Center was noted and appreciated.

Reference Committee "C"

Elmer L. Grimes, M.D., Chairman

Reference Committee "C" met on Sunday, June 6, 1976, with all members present: Doctors William J. D'Elia, Gustav L. Ibranyi, Kenneth W. Mahan, Walter G. Scheuerman, Frank M. Galioto (alternate), and the chairman. Approximately 134 delegates and members were present to discuss the various items under consideration. The meeting was so large that it had to be moved from the assigned Hunterdon Room to the Delegate's Room.

1. Medical-Surgical Plan of New Jersey (page Tr 86)

Dr. Donnelly was asked about payment for psychiatrists. He pointed out that if psychiatrists were employed by a hospital they would not be covered by Blue Shield. If on the other hand they were self-employed, consideration would have to be given to their payment. Dr. Donnelly will look into this.

He also stated that Blue Shield will pay for office surgical procedures if they conform to an approved list. Such office procedures could be done less expensively than when performed in hospital out-patient departments.

In response to questions about payment for lab procedures, Dr. Donnelly outlined the desirability of payment to certified well-equipped laboratories. The modernization of these facilities has contributed to a reduction in the cost of laboratory studies.

The Committee **recommends** that the report be filed.

Adopted

2. Medical Defense and Insurance (page Tr 32) and Supplementals #1 and #2 (page Tr 39 and page Tr 40)

In the discussion Dr. Kreutz announced that there would be an increase in the premiums for the Medical Society's participation in the Plan. This will amount to a 54 percent increase in the Blue Cross segment and 21 percent increase in the Blue Shield. He stated that the cash claims from the group were exceeding the premium payments. It was also noted that the coverage for the doctor's group was much broader than the public enrollment.

In regard to professional liability, Dr. Kreutz outlined the numerous meetings of the Committee to attempt an equitable fee schedule for all the classes of the medical profession. The Committee felt that it would be justifiable to increase the lower class's fees in order to preserve the existence of the higher class specialty groups which have had a prohibitive rise in malpractice premiums. This resulted in a 3 to 3 deadlock vote within the Committee whereupon the project was moved to the Ad Hoc Committee where several alternatives were considered and thence to the Board of Trustees from which culminated the current plan.

Mr. Britton cited the severe losses by Employer's Mutual of Wausau over the years and stated that Chubb's premium rise is in anticipation of similar delayed rise in claims. He emphasized that the Chubb Company would like very much to participate in the insurance program of The Medical Society of New Jersey but they would be unable to carry on without the projected premium increase.

Dr. Collins of New York presented the current status of the Mutual Insurance Company instituted by the Medical Society of New York. Currently the malpractice fees being charged by the insurance company to the doctors roughly parallel the schedule of fees for New Jersey outlined in Supplemental Report #2 of the Committee on Medical Defense and Insurance.

Dr. Kreutz emphasized that the Insurance Committee also has looked into the possibility of a similar mutual insurance company and he noted that Mr. Maressa will be submitting a report on this study later in the month.

Numerous discussors emphasized the crisis state of malpractice in New Jersey and that relief must be sought. Dr. Kreutz stated that he had been contacted by the Academy of Family Physicians and the Academy of Pediatrics who voiced objection to the increased premium rates in their classification.

The Committee **recommends** that the recommendations contained in the annual and supplemental reports be approved and the balance of the reports be filed.

Adopted

3. Ad Hoc Committee on Professional Liability (page Tr 83)

The comments stated under the Medical Defense and Insurance report apply also to this report.

The Committee **recommends** that the report be filed.

Adopted

4. Retirement Plan for Physicians (page Tr 84)

The Committee **recommends** that the report be filed.

Adopted

5. Resolutions:

(a) Assignment of Benefits — Resolution #4 (page Tr 99)

Dr. Donnelly stated that the concept of direct payment to Blue Shield participating physicians and payment to patients directly, in the instance of non-participating physicians, is in the original charter and he felt certain that the Insurance Commissioner would not approve a change. Discussion requested a direct approach to the Insurance Commissioner on this issue.

The Committee **recommends** that Resolution #4 be rejected.

Not adopted

Resolution #4 was adopted by the House.

(b) Mandatory Payment of Professional Liability Assessment — Resolution #5 (page Tr 99)

(c) Professional Liability Assessment — Resolution #7 (page Tr 100)

The Committee considered Resolutions #5 and #7 together. Dr. Todd pointed out that only 1,250 members have paid the \$200 Professional Liability Assessment and that 1,453 members have paid part of the assessment.

The Committee **recommends** that Resolution #5 and Resolution #7 be adopted.

Adopted

Note: A suggested amendment (from the floor of the House) to Resolutions #5 and #7 — that for those individuals who have reached age 65 by July 1, 1976 and for those who have been in practice less than two years as of July 1, 1976, the assessment be made voluntary — was lost.

(d) Blue Shield Claim Form — Resolution #24 (page Tr 109)

In the discussion an appeal was made for standard forms and standard nomenclature. The vast cost increase of reprocessing rejected claims, and so on, was enlightening.

While the claim form in question differs from those employed by other carriers, the Committee does not find it oppressive or difficult to complete.

The Committee **recommends** that Resolution #24 be rejected.

Not adapted

Resolution #24 was amended by the House by deletion of "affixing an itemized bill to the insurance form, or by" in the first "Resolved" and "in lieu of the use of separate claim forms" in the second "Resolved."

Adapted as amended by the House.

Dr. Adolph Wichman then inquired about the status of Resolution #34 from 1975. He made an appeal for the Medical Society's support for doctors who are involved in nuisance suits. He presented documentation for doctors instituting counter suits in cases of unjustified litigation. Numerous discussors felt that funds, probably from the \$200 assessment, might well form the basis of financial support for such individuals.

The Reference Committee **recommends** that this issue be referred to the Ad Hoc Committee on Professional Liability for affirmative action.

Chair ruled the above item was not appropriate for action by the House.

Reference Committee "D"

Francis X. Keeley, M.D., Chairman

Reference Committee "D" met on Saturday, June 5, 1976, with all members present: Doctors Alfonse A. Cinotti, Donald J. Holtzman, Frederick J. Knocke, Gerald H. Rozan, Joseph J. Kinney (alternate), and the chairman. Approximately 44 delegates and members were present to discuss the various items under consideration.

1. Medical Education (page Tr 42)

The Committee **recommends** that the report be filed.

Adapted

2. Emergency Medical Care (page Tr 77)

The Committee **recommends** that the report be

filed.

Adapted

3. Medicine and Religion (page Tr 82)

The Committee **recommends** that the report be filed.

Adapted

4. Resolutions:

(a) **Continuing Medical Education** — Resolution #8 (page Tr 100)

The Committee felt that active efforts are under way by both MSNJ and the AMA to simplify and improve the method of recording participa-

tion in continuing medical education. This system now is basically an honor system. The physician reports his own activities which are taken at face value.

The Committee **recommends** that Resolution #8 be rejected.

Adopted

(b) **CME Requirement** — Resolution #18 (page Tr 105)

It was the overall consensus of members, delegates, and the Committee, that sufficient notice had been given to the membership. It was also pointed out that because of unavoidable lag in reporting noncompliance, a grace period of three to six months is built into the system.

The Committee **recommends** that Resolution #18 be rejected.

Adopted

(c) **High Fees For Participation in Continuing Medical Education Programs** — Resolution #23 (page Tr 108)

The Reference Committee, with the approval of the sponsors, **recommends** that Resolution #23 be amended to read as follows:

RESOLVED, that The Medical Society of New Jersey is opposed to charging a participant a fee in excess of the reasonable cost of providing the educational program; and be it further

RESOLVED, that the sponsoring agency be required to indicate whether it is a profit or non-profit educational endeavor; and be it further

RESOLVED, that the New Jersey Delegation to the AMA be instructed to introduce the above resolution at the AMA meeting in Dallas.

The Committee **recommends** that Resolution #23 be adopted, as amended.

Adopted

(d) **Exemptions From Continuing Medical Education Requirements** — Resolution #28 (page Tr 110)

This Resolution was almost unanimously supported by members, delegates, and the Committee. Educational credit for Category I can be obtained by non-clinical physicians for special educational activities related directly to their occupation. The Committee felt there was no necessity for an exemption to the requirements.

The Committee **recommends** that Resolution #28 be adopted.

Adopted

Reference Committee "E"

Robert H. Areson, M.D., Chairman

Reference Committee "E" met on Sunday, June 6, 1976, with all members present: Doctors Edward P. Healey, Nicholas E. Marchione, Kenneth A. Morrissey, Benjamin Wolfson, Jerome A. Dolan (alternate) and the chairman. Approximately 50 delegates and members were present to discuss the various items under consideration.

1. Board of Trustees

Component and Specialty Society Legal and Legislative Activities (page Tr 18)

The Committee **recommends** that the report be filed.

Adopted

2. **Legislation** (page Tr 54) and Supplementals #1 and #2 (Tr 56 and Tr 62)

(a) In consequence of its action on Resolution #36 the Committee **recommends** that MSNJ's official position on S-889 (Supplemental #1, page Tr 60) be changed from "Approved" to "Conditional Approval."

House amended recommendation of the Reference Committee and changed position from "Approved" to "Active Opposition."

Adopted as amended by the House.

(b) As a result of considerable discussion particularly by members representing the New Jersey Academy of Ophthalmology and Otolaryngology, the Committee **recommends** the following changes in the official positions of MSNJ on the following bills:

S-910 (Supplemental #1, page Tr 60) From "No Action" to Disapproved".

S-1006 (Supplemental #1, page Tr 60) From "Disapproved" to "No Action".

S-1007 (Supplemental #1, page Tr 61) From "Action Deferred" to "No Action".

S-1008 (Supplemental #1, page Tr 61) From "Action Deferred" to "Approved".

S-1245 (Supplemental #1, page Tr 62) From "Active Support" to "Conditional Approval".

A-1453 (Supplemental #2, page Tr 66) From "Action Deferred" to "Disapproved".

A-1538 (Supplemental #2, page TR 67) From "Action Deferred" to "No Action".

By action of the House, all items under 2 (b) were referred to the Council on Legislation for reconsideration with the remarks of the Reference Committee as informational.

(c) The Committee **recommends** rewording the statement on A-69 (Supplemental #2, page Tr 63) as follows: "Disapproved, because it is not in the best interest of the public *or good medical practice.*" (Italicized portion indicates addition)

Adopted

(d) The Committee further **recommends** rewording the final statement of A-88 (Supplemental #2, page Tr 63) as follows: "because this action would support the position of the AMA regarding such billings."

Not Adopted

The Committee would additionally then **recommend** that the official position of MSNJ on A-88 be changed from "Disapproved" to "Approved."

Adopted

Throughout the Reference Committee hearings it was evident that there is a substantial communications gap between the Council on Legislation and various Specialty Societies. With this in mind, the Reference Committee specifically **recommends** to the Council on Legislation that it:

(1) provide advance written notice with written proposed agenda of its meetings to all official New Jersey Specialty Societies as far in advance as possible.

Not Adopted

(2) provide digests or wherever possible the actual copies of bills under legislative consideration to the particular specialty society(ies) involved in advance of Council meetings.

Not Adopted

(3) take no position on legislative items without prior consultation with the particular specialty society(ies) involved.

Not adopted

The Committee **recommends** that the report and Supplementals #1 and #2 be filed.

Adopted

3. **Public Relations** (page Tr 75)

The Committee **recommends** that the report be filed.

Adopted

The Committee further notes the completion of Dr. Howard D. Slobodien's term on the Council and as its Chairman. We commend him for a job well done.

4. **Resolutions:**

(a) **Definition of Optometry** — Resolution #9 (page Tr 101)

The Committee **recommends** that Resolution #9 be adopted.

Adopted

(b) **Legislation Restricting the Use of Physician's Assistants Singling Out One Particular Medical Specialty** — Resolution #10 (page Tr 101)

The Committee **recommends** that Resolution #10 be adopted.

Adopted

(c) **Time Within Which a Minor's Suit Can be Brought for Personal Injuries** — Resolution #11 (page Tr 102)

The Committee **recommends** that Resolution #11 be adopted.

Adopted

(d) **Use of Drugs by Non-Medical Practitioners** — Resolution #12 (page Tr 102)

The Reference Committee was requested by its sponsors to insert the word "eye" between "non-medical" and "practitioners" in lines 1, 7, and 12 and in the title.

The Committee **recommends** this amendment to the resolution and that this resolution be adopted as amended.

Adopted as amended by the Reference Committee

(e) **Involuntary Commitment** — Resolution #20 (page Tr 106)

The Committee **recommends** that Resolution #20 be adopted.

Adopted

(f) **Physician Employment and Utilization of Ancillary Personnel and/or Physicians' Assistants** — Resolution #30 (page Tr 110)

The Reference Committee noted the Board of

Trustees Resolution "that the House of Delegates take a firm and positive position on the use of ancillary personnel and physicians' assistants."

Unhappily the Reference Committee did not feel it had sufficient time and/or expertise to offer the House a reasonable position for vote on this important matter.

The Reference Committee **recommends**, therefore, that the Society's position be evaluated by the Council on Medical Services and a report be made to the Board of Trustees by November 1, 1976.

Not Adopted

Resolution #30 was amended by the House to read as follows:

RESOLVED, that the position of the House be implemented through definitive action on S-831 and S-1354 of 1976, and that this definitive action be active opposition to these bills.

Adopted as amended by the House

(g) **Actively Oppose S-889** — Resolution #36 (page Tr 113)

The Committee approved the intent of Resolution #36 but recognized that the prosecutor's office must clearly be notified in suspected cases of child abuse. Such cases in turn must also have referral to the Division of Youth and Family Services.

The Reference Committee therefore **recommends** that Resolution #36 be not adopted and that the official position of MSNJ on S-889 be changed from "Approved" to "Conditional Approval" (conditional to the prosecutor's office having responsibility to report such suspected cases to the Division of Youth and Family Services.)

Not Adopted

By action of the House MSNJ's position on S-889 was changed from "Approved" to "Active Opposition." Resolution #36 was adopted by the House.

The Chairman wishes to thank the members of the Reference Committee and dedicated members of the Society who spent much time and gave helpful advice to the matters under consideration.

Reference Committee "F"

Daniel E. Boyle, M.D., Chairman

Reference Committee "F" met on Sunday, June 6, 1976, with all members present: Doctors William J. Chase, Paul H. Pettit, Carl A. Restivo, Robert A. Weinstein, John P. Kenger (alternate), and the chairman. Approximately 36 delegates and members were present to discuss the various items under consideration.

1. Board of Trustees

(a) Amendment of Medicaid Legislation (page Tr 18)

The Committee **recommends** that the report be filed.

Adopted

(b) Federal Catastrophic Health Insurance (page Tr 18)

The Committee **recommends** that the report be filed.

Adopted

(c) Federal Regulations Mandating Hospital Utilization or Peer Review Procedures (page Tr 18)

The Committee **recommends** that the report be filed.

Adopted

(d) Federal Utilization Review Regulations (page Tr 18)

The Committee **recommends** that the report be filed.

Adopted

(e) Hospital Application Forms for Present and New Staff Members (page Tr 19)

The Committee **recommends** that the report be filed.

Adopted

(f) Independent Physicians' Associations and/or Prepaid Health Care Contracts (page Tr 19)

The Committee **recommends** that the report be filed.

Adopted

(g) Major and Minor Surgery (page Tr 19) and Supplemental #2 (page Tr 23)

The Committee **recommends** that the report be filed.

Adopted

(h) National Health Planning and Resources Development Act of 1974 (page Tr 20)

The Committee **recommends** that the report be filed.

Adopted

(i) Position Statement on HSA Area Designations (page Tr 20)

The Committee **recommends** that the report be filed.

Adopted

(j) Position Statement on the Practice of Radiology (page Tr 21)

The Committee **recommends** that the report be filed.

Adopted

(k) Proposed Shared Health Care Facilities Regulations (page Tr 21)

The Committee **recommends** that the report be filed.

Adopted

(1) Proposed Standards for Licensure of Ambulatory Care Facilities (page Tr 22)

The Committee **recommends** that the report be filed.

Adopted

(m) Repeal Earnings Test for Social Security (page Tr 22)

The Committee **recommends** that the report be filed.

Adopted

2. Medical Services (page Tr 68)

The Committee **recommends** that the report be filed.

Adopted

3. Occupational Health, Workmen's Compensation, and Rehabilitation (page Tr 68)

The Committee **recommends** that the report be filed.

Adopted

4. Medicaid (pages Tr 5, 81)

The Committee **recommends** that the report be filed.

Adopted

5. Membership Inquiries and Complaint Committees (page Tr 82)

The Committee **recommends** that the report be filed.

Adopted

6. Mental Health (page Tr 69)

The Committee **recommends** that the report be filed.

Adopted

7. Alcoholism (page Tr 69)

The Committee **recommends** that the report be filed.

Adopted

8. Drug Abuse (page Tr 70)

The Committee **recommends** that the report be filed.

Adopted

9. Emotional Disorders of Childhood and Adolescence (page Tr 70)

The Committee **recommends** that the report be filed.

Adopted

10. Mental Retardation (page Tr 71)

The Committee **recommends** that the report be filed.

Adopted

11. Neurological and Related Disorders (page Tr 71)

The Committee **recommends** that the report be filed.

Adopted

12. Resolutions:

(a) Medical Hypnosis in the State of New Jersey — Resolution #13 (page Tr 103)

The Committee **recommends** that the second paragraph in the first "resolved" be amended to read as follows:

(2) Request that the administrator act for

change by encouraging the concept that hypnosis is of value to general practitioners as well as the medical specialist with a background in medical psychopathology; and be it further

Adopted

The Committee **recommends** that Resolution #13 be adopted as amended.

Adopted as amended by the Reference Committee

(b) **Teenage Alcoholism** — Resolution #17 (page Tr 104)

The Reference Committee was of the opinion that Resolution #17 would be impractical to implement.

The Committee **recommends** that Resolution #17 be not adopted.

Not adopted

Resolution #17 was adopted as amended by the House by inclusion of "and the State Department of Education" after the word "Governor" in line 3 of the Resolved."

(c) **Social Security Number as a Universal Numbering Identifier** — Resolution #22 (page Tr 107)

The Committee **recommends** that Resolution #22 be adopted.

Adopted

Reference Committee "G"

Howard H. Lehr, M.D., Chairman

Reference Committee "G" met on Saturday, June 5, 1976, with all members present: Doctors Roger C. Laauwe, Ralph A. Fioretti, Arthur A. Goldfarb, Edwin Messey, Arthur Lawrence (alternate), and the chairman. Approximately 30 delegates and members were present to discuss the various items under consideration.

1. Board of Trustees

Ad Hoc Committee on Blood Procurement (page Tr 22)

The Committee felt that the report rendered did not fully address itself to the needs or the issues, and that if the Committee is having difficulty in organizing blood procurement in New Jersey, they should state those reasons specifically in their report.

The Committee felt that strong efforts should be made by The Medical Society of New Jersey to

prevent New Jersey from being divided into metropolitan areas involving other states.

The Committee **recommends** that the report be filed.

Adopted

2. Chronically Ill and Aging (page Tr 77)

The Committee **recommends** that the report be filed and the Committee be commended for its new programs.

Adopted

3. Public Health (page Tr 72)

The Committee **recommends** that the report be filed, but notes that no member of the Committee was present to discuss the report.

Adopted

4. Cancer Control (page Tr 72)

The Committee **recommends** that the report be filed.

Adopted

5. Child Health (page Tr 73)

The Committee **recommends** that the report be filed.

Adopted

6. Conservation of Vision, Hearing, and Speech (page Tr 73)

The Committee disapproves the recommendation that the Board of Governors of the New Jersey Academy of Ophthalmology and Otolaryngology be established as the Committee on Conservation of Vision, Hearing, and Speech of The Medical Society of New Jersey, as inappropriate.

Adopted

The Committee **recommends** that the Board of Trustees explore closer ties with the Academy of Ophthalmology and Otolaryngology.

Adopted

The Committee **recommends** that the report be filed.

Adopted

7. Environmental Health (page Tr 74)

The Committee **recommends** the report be filed.

Adopted

8. Maternal and Infant Welfare (page Tr 74)

The Committee **recommends** that the report be filed.

Adopted

9. Resolutions:

(a) Creation of a Special Committee on Hearing and Speech — Resolution #14 (page Tr 103)

The Committee **recommends** that Resolution #14 be adopted.

Adopted

(b) Health and Nutrition Program for New Jersey Schools — Resolution #19 (page Tr 105)

The Committee **recommends** that Resolution #19 be adopted, but notes that there may be physicians in New Jersey who are not members of The Medical Society of New Jersey who are better qualified to serve on a nutrition advisory committee.

Adopted

(c) Program of Minimal Primary and Secondary Prevention — Resolution #21 (page Tr 107)

The Committee **recommends** that Resolution #21 be disapproved, but that the concept of minimal primary and secondary preventive medicine be endorsed by the House of Delegates, and that Resolution #21 be forwarded to the Council on Public Health to review the scientific data underlying this proposal.

Not adopted

Upon motion by the House, Resolution #21 was referred to the Council on Public Health.

The Committee further **recommends** that the author of the Resolution, Donald B. Louria, M.D., publish his article in *The Journal* of The Medical Society of New Jersey, so that the membership will become better acquainted with these newer principles of preventive medicine.

The Choir ruled that the above recommendation of the Reference Committee was not appropriate for consideration by the House.

(d) Support For An Appropriate Swine Influenza Immunization Program — Resolution #31 (page Tr 111)

The Committee **recommends** that Resolution #31 be adopted.

Adopted

(e) **Cancer Prevention** — Resolution #34 (page Tr 112)

The Committee **recommends** that the "Resolved" portion of Resolution #34 be amended to read as follows: (amended portion indicated by italics)

"RESOLVED, that The Medical Society of New Jersey strongly urge that the full weight of governmental, medical, industrial, and public expertise be quickly brought to bear on *the problem of cancer in the State of New Jersey*; and be it further

"RESOLVED, that sufficient funding be obtained and expert staff organized in order that appropriate legislation and regulations be quickly developed *in consultation with The Medical Society of New Jersey in an attempt* to decrease the horrendous rate of cancer in people of this State.

The Committee **recommends** that Resolution #34 be adopted as amended.

Adopted as amended by the Reference Committee.

(f) **Atomic Energy Plants** — Resolution #40 (page Tr 114)

The Committee **recommends** that the "Resolved" portion of this Resolution be amended to read as follows:

RESOLVED, that The Medical Society of New Jersey vigorously support

(1) further study of the health implications of an atomic energy plant off the coast of New Jersey, and that

(2) a Committee of selected physicians be appointed (by the Board of Trustees) for the urgent task of meeting with the scientists of the appropriate nuclear energy commission as soon as possible and that their findings be reported to the 1977 House of Delegates of The Medical Society of New Jersey.

The Committee **recommends** that Resolution #40 be adopted as amended.

Adopted as amended by the Reference Committee.

(g) **Serology Testing and Health** — Resolution #41 (page Tr 115)

The Committee **recommends** that Resolution #41 be disapproved.

Adopted

Reference Committee "H"

Fred M. Palace, M.D., Chairman

Reference Committee "H" met on Sunday, June 6, 1976, with all members present: Doctors Aldo G. Baldi, Harry W. Fullerton, Jr., Edward H. Weiser, Michael J. Horan, Jr., Frank R. Schell (alternate), and the chairman. Approximately 20 delegates and members were present to discuss the various items under consideration.

1. Annual Meeting (page Tr 26)

In addition to the annual report of the Committee, Dr. Gardam, Chairman of the Com-

mittee on Annual Meeting, suggested that the Board of Trustees combine the Standing Committee on Annual Meeting and the Committee on Scientific Exhibits for ease in future planning.

It was requested that in the future, the annual meeting of the Woman's Auxiliary and that of MSNJ be housed in the same hotel.

Many other suggestions were made that will be transmitted to the Committee on Annual Meeting in memorandum form.

The Committee **recommends** that the report be filed and that the recommendations be approved.

By action of the House, Resolution #16 (Item 7 (b)) was considered before action was taken on the recommendations of the Reference Committee concerning the report of the Annual Meeting Committee.

Recommendation #1 of the Annual Meeting report was not adopted.

Recommendation #2 was adopted.

Upon motion from the floor, the House directed that the Committee on Annual Meeting, with the advice and consent of the Board, be authorized to select the site for the 1977 annual meeting.

2. Scientific Program (page Tr 26)

The Committee **recommends** that the report be filed.

Adopted

3. Scientific Exhibits (page Tr 26)

The Committee **recommends** that the report be filed.

Adopted

4. Honorary Membership (page Tr 27)

The Committee **recommends** that the report be filed.

Adopted

5. Woman's Auxiliary Advisory (page Tr 53)

The Committee **recommends** that the report be filed.

Adopted

6. Nominations for Emeritus Membership (page Tr 94) and Supplementals (page Tr 95)

The Committee **recommends** that the report be filed.

Adopted

7. Resolutions:

(a) Commendation to Arthur Bernstein, M.D. — Resolution #15 (page Tr 104)

The Committee **recommends** that Resolution #15 be adopted.

Adopted by acclamation

(b) Return Annual Meeting to Atlantic City — Resolution #16 (page Tr 104)

The Committee **recommends** that Resolution #16 be tabled and referred to the Committee on Annual Meeting for consideration and report back at the next regular meeting of the House of Delegates.

Not Adopted

By action of the House, Resolution #16 was referred to the Committee on Annual Meeting.

The Reference Committee expressed its thanks to James E. D. Gardam, M.D., Chairman of the Committee on Annual Meeting, and to Robert H. Lambert, MSNJ Business and Financial Manager, for their attendance and information during the Committee's deliberations.

Report of the Nominating Committee and Election

James A. Rogers, M.D., Chairman

Office	Term	Nominee and County
President-Elect	1 year	Frank R. Begen, M.D., Bergen
1st Vice-President	1 year	Charles S. Krueger, M.D., Burlington
2nd Vice-President	1 year	^a Alfred A. Alessi, M.D., Bergen
Secretary	1 year	Arthur Bernstein, M.D., Essex
Treasurer	1 year	Rudolph C. Gering, M.D., Mercer
Trustees		
1st District	3 years	^b Augustus L. Baker, Jr., M.D., Morris
4th District	3 years	Anthony P. DeSpirito, M.D., Monmouth
4th District	3 years	Meyer L. Abrams, M.D., Burlington
5th District	3 years	Armando F. Goracci, M.D., Gloucester
Judicial Councilors		
3rd District	3 years	Albert F. Moriconi, M.D., Mercer
AMA Delegates:		
	1 year	James S. Todd, M.D., Bergen
	2 years	George L. Benz, M.D., Essex
	2 years	Frank J. Hughes, M.D., Camden
	2 years	Karl T. Franzoni, M.D., Mercer
	2 years	Emanuel M. Satulsky, M.D., Union
	2 years	Robert E. Verdon, M.D., Bergen
AMA Alternate Delegates:		
	1 year	Howard D. Slobodien, M.D., Middlesex
	2 years	John J. Bedrick, M.D., Hudson
	2 years	Henry J. Mineur, M.D., Union
	2 years	Myles C. Morrison, Jr., M.D., Morris
	2 years	James H. Spillane, M.D., Warren
Delegates and Alternate Delegates to Other States:		
New York		
Delegate	1 year	Albert F. Moriconi, M.D., Mercer
Alternate	1 year	F. Sterling Brown, M.D., Atlantic
Connecticut		
Delegate	1 year	Edward G. Bourns, M.D., Union
Alternate	1 year	Gastone A. Milano, M.D., Atlantic
Administrative Councils:		
Legislation		
2nd District	3 years	John J. Crosby, Jr., M.D., Hudson
3rd District	3 years	Leon A. Fraser, M.D., Mercer
5th District	2 years	^c Samuel B. Pole, III, M.D., Cumberland
Medical Services		
2nd District	3 years	John R. O'Brien, M.D., Hudson
3rd District	3 years	Frank Campo, M.D., Mercer
Mental Health		
4th District	3 years	George L. Triebenbacher, M.D., Ocean
5th District	3 years	Alan Kulick, M.D., Cape May
Public Health		
1st District	1 year	Edward M. Coe, M.D., Union
2nd District	3 years	Edward A. Wolfson, M.D., Passaic
3rd District	3 years	Thomas F. McLaughlin, M.D., Middlesex
Public Relations		
3rd District	3 years	Milton R. Bronstein, M.D., Middlesex
6th Member	3 years	Edwin W. Messey, M.D., Burlington
Standing Committees		
Annual Meeting	3 years	Robert Brill, M.D., Passaic
Finance and Budget	3 years	Edward A. Jasionowski, M.D., Middlesex
Medical Defense		
and Insurance	3 years	^d Michael J. Doyle, M.D., Monmouth
Medical Education	3 years	Frank C. Snope, M.D., Hunterdon
Publication	3 years	Daniel B. Roth, M.D., Bergen
Woman's		
Auxiliary Advisory	3 years	Alexander D. Kovacs, M.D., Union

Accepted by the House

^aDr. Alessi was nominated and elected from the floor of the House. The Nominating Committee's choice was Augustus L. Baker, Jr., M.D., of Morris County

^bDr. Baker was nominated and elected from the floor of the House. The Nominating Committee's choice was Douglas M. Costabile, M.D., of Union County.

^cDr. Pole was nominated and elected from the floor of the House. The Nominating Committee's choice was Wilbert R. Staub, M.D., of Salem County.

^dDr. Doyle was nominated and elected from the floor of the House. The Nominating Committee's choice was Ralph Cavalier, M.D., of Atlantic County.

The not-so-obvious need:

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Pyridoxine HCl (Vitamin B ₆)	5 mg
Niacinamide	100 mg
Calcium pantothenate	20 mg
Cyanocobalamin (Vitamin B ₁₂)	5 mcg
Folic acid	0.5 mg
Ascorbic acid (Vitamin C)	500 mg

Indications: Nutritional supplementation in conditions in which water-soluble vitamins are required prophylactically or therapeutically

Warning: Not intended for treatment of pernicious anemia or other primary or secondary anemias. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with pernicious anemia who receive more than 0.1 mg of folic acid per day and who are inadequately treated with vitamin B₁₂.

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ATTENDANCE

Official Attendance Report

County	Delegates	Members	Total
Atlantic	8	18	26
Bergen	40	40	80
Burlington	11	38	49
Camden	25	115	140
Cape May	3	—	3
Cumberland	4	9	13
Essex	63	117	180
Gloucester	5	21	26
Hudson	25	29	54
Hunterdon	3	2	5
Mercer	25	62	87
Middlesex	20	31	51
Monmouth	24	41	65
Morris	21	16	37
Ocean	10	19	29
Passaic	33	34	67
Salem	3	7	10
Somerset	6	14	20
Sussex	3	3	6
Union	33	49	82
Warren	2	3	5
Fellows and Officers	23	—	23
	<u>390</u>	<u>668</u>	<u>1,058</u>
Physician Guests			85
Physician Exhibitors			4
TOTAL PHYSICIAN REGISTRATION			<u>1,147</u>
Auxiliary			247
Visitors			333
Exhibitors			194
TOTAL REGISTRATION			<u>1,948</u>
REGISTRATION OF HOUSE OF DELEGATES			
Registration:			
Total Possible — Officers and Fellows			28
Total Possible — County Delegates			<u>396</u>
Total 1976 House of Delegates			424
Total Officers and Fellows Registered			23
Total County Delegates Registered			<u>367</u>
Total Registered			<u>390</u>
Attendance at House Sessions			
1st Session, 6/5/76			336
2nd Session, 6/6/76			356
3rd Session, 6/7/76 Part I			346
6/8/76 Part II			325
Average for All Sessions			341

THERAPEUTIC FOCUS ON CAPSULES, 25 mg and 50 mg **INDOCIN[®]** **(INDOMETHACIN | MSD)**

*helps relieve pain
and other symptoms
of inflammation
in acute
gouty arthritis
in selected patients*

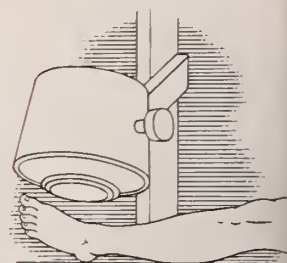
INDOCIN is a potent drug with anti-inflammatory, antipyretic, and analgesic properties. It should not be used in conditions other than those recommended. Although INDOCIN does not alter the progressive course of the underlying disease, in selected patients with acute gouty arthritis it has been found highly effective in relieving pain and in reducing fever, swelling, and tenderness.

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For a brief summary of prescribing information, please see following page.

addendum
M
V
E
S
S

Facts about Scintiphotography



In recent years a variety of radiopharmaceuticals have been employed to aid in the diagnosis of bone and joint disorders. The joint-imaging technique consists of injecting technetium polyphosphate intravenously, and imaging is performed with the scintillation camera two hours after the administration of the radionuclide. In general, for joint surveying, the shoulders, elbows, hands, wrists, knees, ankles, feet, and vertebral column are mapped. The entire scanning process takes approximately one hour. The criterion for a positive image is a higher concentration of radioactivity in a joint region than in adjacent nonarticular bone. In effect, each patient serves as his own control.

VISUAL FOCUS ON ACUTE GOUTY ARTHRITIS



Foot of patient with acute gouty arthritis
as seen by conventional x-ray.



Scintiphotogram of same foot reflects
inflammatory process.

The scintiphotograph on the right shows increased uptake of radiotechnetium polyphosphate in the metatarsophalangeal joint and the proximal interphalangeal

joint of the great toe of a patient with acute gouty arthritis. This increased uptake probably results from increased vascularity in the affected areas.

For a more detailed description of scintiphotography,
see "addendum" at right.

INDOCIN[®]

(INDOMETHACIN | MSD)



helps relieve pain
and other symptoms
of inflammation
in acute
gouty arthritis
in selected patients

IMPORTANT NOTE: INDOCIN (Indomethacin, MSD) cannot be considered a simple analgesic and should not be used in conditions other than those recommended. The drug should not be prescribed for children because safe conditions for use have not been established.

Because of the high potency of the drug and the variability of its potential to cause adverse reactions, the following are strongly recommended: 1) the lowest possible effective dose for the individual patient should be prescribed. Increased dosage tends to increase adverse effects, particularly in doses over 150-200 mg per day without corresponding clinical benefits; 2) careful instructions to, and observations of, the individual patient are essential to the prevention of serious and irreversible, including fatal, adverse reactions, especially in the aging patient.

Contraindications: Children 14 years of age and under; pregnant women and nursing mothers; active gastrointestinal lesions or history of recurrent gastrointestinal lesions; allergy to aspirin or indomethacin.

Warnings: *Gastrointestinal Effects:* Because of the occurrence and, at times, severity of gastrointestinal reactions, be continuously alert for any sign or symptom signaling a possible gastrointestinal reaction. The risks of continuing therapy with INDOCIN in the face of such symptoms must be weighed against the possible benefits to the individual patient. Gastrointestinal effects may be reduced by giving the drug immediately after meals, with food, or with antacids. Use greater care in aging patients.

Ocular Effects: Corneal deposits and retinal disturbances, including those of the macula, have been observed in some patients on prolonged therapy. Discontinue therapy if such changes are observed. Ophthalmologic examination at periodic intervals is desirable in patients on prolonged therapy.

Central Nervous System Effects: INDOCIN may aggravate psychiatric disturbances, epilepsy, and parkinsonism, and should be used with considerable caution in patients with these conditions. If severe CNS adverse reactions develop, discontinue the drug.

Precautions: Blurred vision may be a significant symptom that warrants a thorough ophthalmologic examination. Patients should be cautioned about engaging in activities requiring mental alertness and motor coordination, as driving a car. Headache which persists despite dosage reduction requires complete cessation of the drug. May mask the usual signs and symptoms of infection; therefore, the physician must be continually on the alert for this and should use the drug with extra care in the presence of existing controlled infection. After the acute phase of the disease is under control, an attempt to reduce the daily dose should be made repeatedly until the patient is off entirely.

Drug Interactions: Although INDOCIN has not influenced the hypoprothrombinemia produced by anticoagulants, patients on anticoagulant therapy should be observed closely for alterations in prothrombin time. In patients receiving probenecid, plasma levels of indomethacin are likely to be increased and a lower total daily dose of INDOCIN may produce a therapeutic effect; increases in the dose of INDOCIN should be made cautiously and in small increments.

Adverse Reactions: *Gastrointestinal Reactions:* Single or multiple ulcerations of the esophagus, stomach, duodenum, or small intestine, including perforation and hemorrhage, with fatalities in some instances; rarely, intestinal ulceration has been associated with stenosis and obstruction; gastrointestinal bleeding without obvious ulcer formation; perforation of preexisting sigmoid lesions (diverticulum, carcinoma, etc.); rarely, increased abdominal pain in ulcerative colitis patients or development of ulcerative colitis and regional ileitis; gastritis may persist after the cessation of the drug; nausea, vomiting, anorexia, epigastric distress, abdominal pain, and diarrhea.

Eye Reactions: Corneal deposits and retinal disturbances, including those of the macula, have been observed on prolonged therapy; blurring of vision.

Hepatic Reactions: Rarely, toxic hepatitis and jaundice, including some fatal cases.

Hematologic Reactions: Aplastic anemia, hemolytic anemia, bone marrow depression, agranulocytosis, leukopenia, and thrombocytopenic purpura may occur rarely. Since some patients manifest anemia secondary to obvious or occult gastrointestinal bleeding, appropriate blood determinations are recommended.

Hypersensitivity Reactions: Acute respiratory distress, a rapid fall in blood pressure resembling a shock-like state, angioedema, dyspnea, asthma, angitis, pruritus, urticaria, skin rashes, purpura.

Ear Reactions: Hearing disturbances—deafness reported rarely; tinnitus.

Central Nervous System Reactions: Psychic disturbances including psychotic episodes, depersonalization, depression, and mental confusion; coma; convulsions; peripheral neuropathy; drowsiness; lightheadedness; dizziness; syncope; headache.

Cardiovascular-Renal Reactions: Edema, elevation of blood pressure, hematuria.

Dermatologic Reactions: Loss of hair, erythema nodosum.

Miscellaneous: Rarely, vaginal bleeding, hyperglycemia, glycosuria, ulcerative stomatitis, and epistaxis.

Supplied: Capsules containing 25 mg indomethacin each, in single-unit packages of 100 and bottles of 100 and 1000; capsules containing 50 mg indomethacin each, in single-unit packages of 100 and bottles of 100.

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Golden Merit Awards

President's Remarks at 1976 Ceremony*

It is, I think, a most happy circumstance, this privilege of bestowing the Golden Merit Award of The Medical Society of New Jersey upon its distinguished and beloved recipients. I regret that Doctor John McGuire is not here to have this honor, and that he could not have lived to receive this award in 1986.

The Golden Merit Award was established in 1957 as an expression of The Medical Society of New Jersey's pride in, and affectionate regard for those of its members who have completed half a hundred years as doctors of medicine. In bestowing this award, The Medical Society of New Jersey honors itself by identifying with those distinguished men and women who have given a lifetime of devoted service to the people of New Jersey.

Today the award is being conferred upon fifty-nine of our members representing eleven counties — not all of whom are present — and the sum of their years of service reaches the magnificent total of 2,950 years!

Certainly no service was ever more deserving of commendation and acclamation than is theirs. Certainly nothing that we can do at this convention can be more important or significant than to tell these golden jubilarians, in the name of their profession and of their fellowmen, how proud of them we are and how enduringly grateful.

Thank you for giving so much of yourselves, with such noble and prodigal generosity, to your profession and to your fellowmen. Since we know, on the highest authority, that it is much more blessed to give than to receive, you are deservedly among the most blest, the happiest, of people. God keep you so — not only for the many golden years you are yet to enjoy on earth, but always.

RECIPIENTS 1976

Atlantic

Herman Kline, M.D., Atlantic City
Allan Rieck, M.D., Pleasantville,
Louis Rosenberg, M.D., Atlantic City
Levi Walker, M.D., St. Croix, V.I.
F. Rolfe Westney, M.D., Atlantic City
Julius Winston, M.D., Atlantic City

Bergen

Lyman Burnham, M.D., Englewood
George M. Knowles, M.D., Maywood
Francis A. Macaulay, M.D., Boynton Beach, Fla.
Irene C. D. Pindar, M.D., Teaneck
Edward T. Seymour, M.D., Mantaloking
Russell K. Tether, M.D., Demarest

Burlington

Clarence J. Poppen, M.D., Fort Myers, Fla.
Luis E. Viteri, M.D., Mount Holly

Camden

Arthur E. Hirshorn, M.D., Gloucester
Henry G. Marcarian, M.D., Collingswood
Hammell P. Shipp, M.D., Cinnaminson
Max L. Weimann, M.D., Haddon Heights

Essex

Otto Brandman, M.D., Newark
Edward V. Brown, M.D., South Dennis, Me.
Jeremiah L. Buckley, M.D., Lavalette
Francis P. Carrigan, M.D., Bennington, Vt.
Katharine B. Hahn, M.D., Southbury, Ct.
William H. Hahn, M.D., Southbury, Ct.
Fred A. Hasney, M.D., Neptune City
Erwin J. Kaderabek, M.D., New Smyrna Beach, Fla.
Charles O. Leff, M.D., South Orange
Joseph Levin, M.D., Millburn
Aaron Lowenstein, M.D., Maplewood
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William J. H. Abey, M.D., Pennington
H. Donald Cowlbeck, M.D., Trenton
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Norman Plummer, M.D., Wycombe, Pa.

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Alexander A. Podell, M.D., Red Bank

Morris

J. Arthur Byrne, M.D., Morristown

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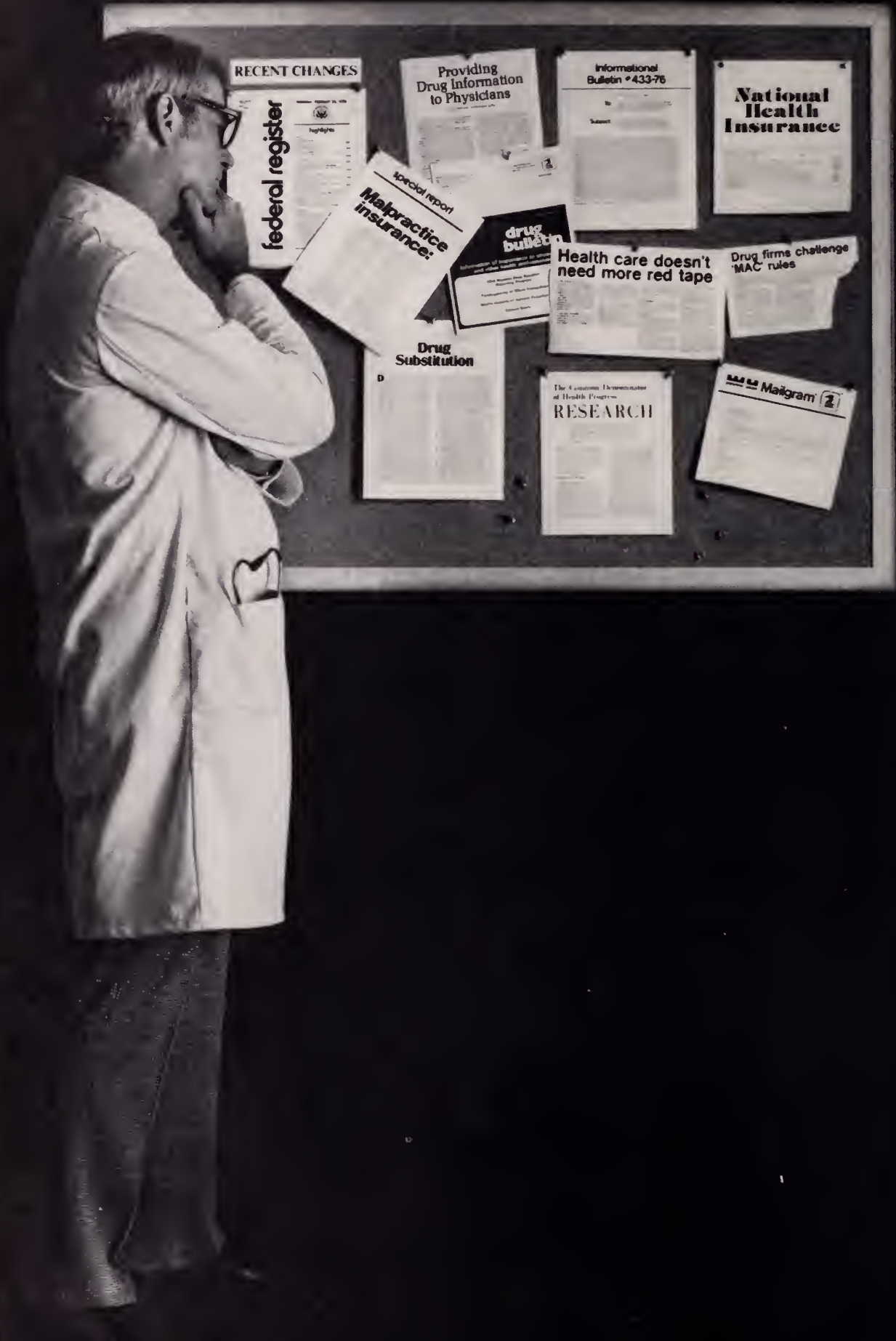
Jacob Averbach, M.D., Clifton
Dale E. Beverly, M.D., West Paterson
Irving A. Silverman, M.D., Clifton
Henry E. Reading, M.D., Pompano Beach, Fla.

Union

Lorrimer B. Armstrong, M.D., Westfield
George Kemeny, M.D., Elizabeth

†deceased

*Saturday, June 5, 1976



RECENT CHANGES

federal register

**Providing
Drug Information
to Physicians**

**Informational
Bulletin #433-76**

**National
Health
Insurance**

**special report
Malpractice
insurance:**

**drug
bulletin**

**Health care doesn't
need more red tape**

**Drug firms challenge
MAC rules**

**Drug
Substitution**

**The Continuing Development
of Health Progress
RESEARCH**

Mailgram 2

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original FDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only the cost of the lowest-priced, purportedly-equivalent,

generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than \$1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



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**What's
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Excerpts from Remarks by Governor Byrne*

I want to express my personal sense of loss at the death of John McGuire. I am proud to call him my friend. And I also share with all of you, I'm sure, admiration and appreciation for the enlightened leadership he brought to The Medical Society of New Jersey as well as to so many other worthy endeavors during his long and distinguished career.

John McGuire exemplified in his practice of medicine and surgery his dedication to the concept that the relationship between government and the private practitioner should be — indeed, must be — one of partnership in the delivery of health care. I will not take the time to review his many contributions in this area. That list is well known to most of you. Let me cite just three.

He was twice secretary of the State Board of Medical Examiners. He served on the steering committee for the Medical Opportunity Fund of the Medical Schools of New Jersey. As a member of a special advisory committee to the State Division of Medicaid, he played a key role in developing a comprehensive list of substitution drugs for that Division's voluntary generic drug substitution program.

I have been asked to speak this morning about some of the unresolved issues affecting health care in New Jersey. I shall try to do so in a spirit of cooperation and partnership between government and the private practitioner which is needed better to serve the health needs of the public whom both are pledged to serve.

Influenza Immunization

Let's start with an issue which carries with it a real sense of urgency — the impending mass immunization program to protect the public against swine flu or, as the federal authorities have officially designated it, "New Jersey Flu."

The press has made some sport out of that decision to name a strain of disease after our state, but I do not cringe from that designation. On the contrary, I take pride in the alertness and

diligence of the New Jersey Department of Health which identified the flu bug responsible for the minor outbreak at Fort Dix some months ago. If our state health officials had been less alert, you and I and our counterparts across the nation would not have had the early warning necessary to make plans in June to meet the threat of a possible epidemic next fall and winter. And, there would not be the vaccine needed to do the job.

I have convened a cabinet-level task force to coordinate government's role in meeting that threat. The task force is headed by State Health Commissioner Joanne Finley, who is here today to take your questions about those plans and the role of the private practitioner in carrying them out. She is in constant touch with the U.S. Public Health Service Center for Disease Control on day-by-day developments.

Let me, if I may, enlist your wholehearted cooperation in the mammoth task we face in making this protection available to all residents of New Jersey. We shall ask each county medical society to assume a leadership role in making the public aware of the importance of participating in the immunization program and in organizing doctors as program volunteers. We will, of course, require at least one attending physician to be present at each mass clinic.

I am aware, as you are, that in the course of any immunization program of this dimension some of those the program is designed to help will find some reason to file a lawsuit against those who are providing that help. I have asked the Attorney General for a legal opinion on the liability of volunteer personnel administering the flu immunization program. I have not yet received that opinion. But I can promise you this: One way or another, we will assure every volunteer protection from liability on the same basis and to the same extent as state and local employees participating in the vaccination program.

Allow me to express the gratitude of the people of New Jersey in advance for the cooperation

*Second Annual Governor's Conference on Primary and Secondary Prevention in Adult Medicine, 210th Annual Meeting, MSNJ, June 5, 1976, Cherry Hill.

which I am confident you will provide as a Medical Society and as individuals in this difficult program. Any of you who are interested in learning more details about planning for the program will be most welcome to attend the Health Department's conference on June 14 at the Rutgers Medical School in Piscataway.

Malpractice Insurance

As a lawyer and a former judge, I am well aware that the threat of lawsuits, and the soaring cost of malpractice insurance is a constant concern of physicians. New Jersey has fared much better than many other states in this regard. Malpractice insurance coverage is available to every member of this Medical Society from the Federal Insurance Company and at rates that have not begun to match the astronomical escalation faced by doctors in California and elsewhere. I take pride in the part played by the State Department of Insurance in achieving that relatively favorable situation.

Having said that, let me hasten to add that I realize it probably provides little solace to the practitioner faced with an insurance premium more than 50 per cent higher than the one he paid last year. The high cost of malpractice insurance is a continuing problem and one which demands the attention of that partnership of government and private practitioners. It is also one, it seems to me, that cries out for innovation and new concepts in insurance.

In concert with State Insurance Commissioner James Sheeran, I am exploring some new concepts, including possible roles for original protection or reinsurance by a government agency or a non-profit corporation. I invite your input into these deliberations, individually and as a medical society. Please share your ideas with us in a memo to me or to Commissioner Sheeran so we can evolve the best possible solution to this mutual concern.

We can, I think, draw encouragement from the success of the manner in which New Jersey hospitals averted an imminent crisis in malpractice insurance for hospitals in partnership with state government. As many of you know, the Hospital Association, with the encourage-

ment and cooperation of Commissioner Sheeran, formed its own insurance company — the Health Care Insurance Exchange — to overcome member institutions' difficulty in obtaining coverage in the standard market. But the Exchange was limited to no more than \$100,000 coverage for each risk under a state law limiting individual risk coverage to 10 per cent of a company's assets. This fell far short of the needs of a number of hospitals.

To meet those needs, this Administration introduced and the Legislature enacted a bill empowering Commissioner Sheeran to activate the New Jersey Medical Malpractice Reinsurance Association, composed of about 400 companies that write personal injury and property damage liability. As a result, the Exchange is able to write million dollar policies for the hospitals and immediately reinsure 90 per cent of the coverage with the Association. The Exchange retains its statutory limit of \$100,000 coverage on each risk. There appears to be a need now to increase the limits of coverage above the million dollar mark, and there are other legal problems affecting the ability of certain hospitals to find acceptable malpractice coverage. We are working on both these problems. This is the kind of innovative partnership between government and the private sector that can work wonders when both partners pull their own weight.

Another example is the sliding fee schedule for lawyers applicable to all tort action including medical malpractice cases. New Jersey is one of the few states which has acted in this area. There is every indication that this system has helped curb big verdicts and thereby support the state's claim profile, helping hold down the rise in malpractice rates.

Certificate of Need and Rate Setting

There are many other health care issues that deserve more attention from our cooperative partnership. There are the certificates of need and rate setting programs, for one. I know that these programs are not universally popular, but I believe there is a growing realization of their value. I suggest to you that the time has come to stop fighting the concept and, instead, to work together to make it work in a rational and

beneficial manner. As the Hospital Association of Pennsylvania acknowledged in a report last fall: "The real payoff in the control of hospital costs lies in certificate of need . . . It is the excessive use of facilities, overabundance of facilities and the uneconomic duplication of facilities that have produced the fat in the nation's health care expenditures."

Certificate of need is indeed the most important cost control tool which directly affects the rate-setting process. If the certificate of need process fails to prevent the addition of unnecessary hospital beds, for example, per diem costs will rise in the other facilities to cover the slack caused by under-utilization. The system has been improved and streamlined significantly during this Administration. Applications are now reviewed every month instead of quarterly, many more items are subject to administrative review, and the cost thresholds have been increased to apply only to major equipment purchases, major service additions or major building modification.

I ask your cooperation in making further improvements so that we can achieve the goal of the enabling statute: "Hospital and related services of the highest quality of demonstrated need, efficiently provided and properly utilized at a reasonable cost are of vital concern to the public health."

Cancer Control — Continuing Education

I recently have appointed a Cabinet Committee on Cancer Control to coordinate state efforts to analyze and control conditions deemed to contribute toward the high incidence of cancer in New Jersey. A key tool in this effort will be development of a registry showing the incidence of diagnosed cancer cases. The Department of Health will obviously rely upon New Jersey's practicing physicians for much needed information. We welcome the counsel of the Medical Society in strengthening this effort to prevent the development of a "Cancer Alley" in our state.

Many physicians attended the Health Department's recent conference on genetic

counseling and its training program on the interaction between drugs and nutrition, presented in conjunction with the New Jersey College of Medicine and Dentistry. The Health Department has made grants to the New Jersey Academy of Medicine for roving symposia to provide continuing educational opportunities for physicians. The reports that reach me indicate that these are most useful undertakings and I look forward to more of them in the future.

Physicians as a Valuable Resource

I recognize the physicians of New Jersey as a valuable resource and one that is not exclusively confined to matters of health care. I have convinced busy physicians to serve on boards and commissions of varied jurisdictions, including my brother, who is on the State Board of Institutional Trustees. I expect to call on more of you in the future. And I also recognize that it is a legitimate responsibility of government to assist, protect and defend the rights and status of the physicians and to preserve the doctor-patient relationship. I look to this Medical Society for guidance as to when such government involvement is needed and for aid in establishing precisely what action is appropriate.

I hope, too, that we can realize some of the many opportunities for joint activity in a number of other areas of mutual concern. Consumer health education and the rapidly expanding field of care for the elderly come immediately to mind.

Let us build and expand upon our partnership with an emphasis on preventive health care through ambulatory clinics and other outpatient facilities where the emphasis remains on the doctor and the patient, working to reduce the need for institutionalization of patients so that an increasing portion of the health care dollar may be directed into preventive care.

To the degree that I am able to influence its course, New Jersey government stands ready to fulfill its responsibility in such a partnership. We will be looking to the Medical Society and to all of you to help make it a reality.

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Trustees' Minutes

Two regular meetings of the Board of Trustees were held during the 1976 Annual Meeting in Cherry Hill. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

June 4, 1976

A-Swine Influenza . . . Received a report from the Executive Director which included the following information pertaining to immunization against A-Swine Influenza: (1) the Commissioner of Health will attend the Second Annual Governor's Conference on June 5 to participate in a discussion of the state-wide immunization program; (2) a meeting for discussion of the immunization program details will be held on June 14 at Rutgers University and it has been requested that the Chairman of the Council on Public Health and the President of the Society attend; and (3) arrangements for inoculations thus far include use of technicians at inoculation centers, the assistance of county medical societies in providing supervisory physician coverage, and assurance from the Governor that any physicians participating in the inoculation program will have absolute immunity from suit.

Legislation . . . Approved the positions recommended by the Council on Legislation on the following bills, with the noted exceptions on A-412, A-1098, and A-1458:

S-1387—To provide for the establishment of a Graduate Medical Education Program. *APPROVED*

S-1404—To provide for confidentiality of child abuse reports and information; to provide penalties for violations. *APPROVED*

S-1419—To create a medical vision advisory panel in the Division of Motor Vehicles. *NO ACTION*

S-1423—To revise penalties for driving while intoxicated; to reduce .15% to .10% alcohol in defendant's blood to presume intoxication; to provide for a program of alcohol education or rehabilitation. *ACTION DEFERRED*, pending further information from the Committee on Alcoholism.

S-1425—To amend the law regulating the practice of pharmacy; to increase from 5 to 7 the number on Board of Pharmacy which includes one public member and to revise certain fees. *NO ACTION*

S-1442—To require all restaurants and temporary retail food establishments to have at least one employee

on duty at all times trained in first aid methods of assisting persons choking. *DISAPPROVED*, because this bill is impossible of implementation.

S-1453—To provide for the establishment of a comprehensive health program in the public schools. *NO ACTION*

S-1454—To conform the Health Care Facilities Planning Act to the National Health Planning and Resources Development Act; to require 7 of the 11 members of the Health Care Administration Board to be health care services consumers and not providers and to permit the Commissioner of Health to set rates for payment by all purchasers of health care services provided by a hospital. *ACTIVE OPPOSITION*, because the expansion of the rate-setting authority of the Commissioner of Health at the present time is inadvisable since the Department of Health has yet to demonstrate that it can efficiently and effectively administer the current law. Further control and regulation while seemingly placing all insurers in the same situation will effectively stifle competition and destroy private initiative in the health insurance field.

S-1456—To permit medical service corporations to provide and insure dental services and to contract with participating dentists. *APPROVED*

A-37—To provide for consent by minors to treatment for mental illness. *DISAPPROVED*, because the bill, as written, is inherently unsound in that it calls for reliable judgment from an individual who by definition is incapable of rendering the same.

A-38—To require the certification of diagnostic information for the use of the county court at final hearings on commitment of patients in mental hospitals where continued care and treatment beyond a 20-day temporary commitment is recommended. *APPROVED*

A-52—To provide for eye examinations of every child enrolled in the kindergarten class and to permit boards of education to authorize examinations for pupils in other grade levels. *DISAPPROVED*, because the school physician already has the obligation to screen for physical defects, including impairment of vision. The additional requirement of an optometrist or a physician licensed to practice medicine in the State of New Jersey would, in consequence, be an unjustifiable and expensive redundancy.

A-53—To direct the Board of Education to require immunization of all pupils against rubella as a condition for entrance to kindergarten and grades one through four. *DISAPPROVED*, because immunization is already mandatory in New Jersey.

A-69—To require that each bio-analytical laboratory be under supervision of a person licensed to practice medicine and surgery and certified in clinical pathology or a licensed bio-analytical laboratory director. *DISAPPROVED*, because it is not in the best interest of the public. Many physicians practicing pathology are certified in anatomical pathology, but not clinical pathology although they have extensive training in that field. Many hospital laboratories are supervised by well-qualified physicians who are not certified specialists in clinical

pathology. Therefore, if this bill is enacted it will create a crisis situation in many New Jersey hospitals that are providing admirable services to the community.

A-88—To provide for direct billing by the providers of clinical laboratory services to the recipient of the services. *DISAPPROVED*, because this concept already exists in current law.

A-111—To require, in place of permit, employment of an optometrist as school vision examiner and a physician to be known as school hearing examiner. *DISAPPROVED*, because the school physician already has the obligation to screen for physical defects, including impairment of vision. The additional requirement of an optometrist or a physician licensed to practice medicine in the State of New Jersey would, in consequence, be an unjustifiable and expensive redundancy.

A-113—To authorize the Commissioner of Education to undertake a comprehensive study of secondary education programs and facilities available to handicapped children. *NO ACTION*

A-117—To provide that the need for a certificate under the act providing for certification of x-ray technicians shall not apply to a licensed dentist and person who operates only x-ray equipment for dental radiographs and only under the direct supervision, to provide for 9 examiners, in place of 10, on the x-ray technician board. *NO ACTION*

A-119—To provide that when a local board of health adopts more stringent health or environmental protection ordinances or regulations than imposed by the Department of Environmental Protection it must obtain the approval of the department. *APPROVED*

A-122—To provide that any person, except a licensed physician, who uses hypnosis for clinical treatment to relieve a person from symptoms of illness or unwanted habits is a disorderly person. *APPROVED*

A-135—To prohibit practitioners from dispensing methadone without approval of the Commissioner of Health after first informing him of the name of the individual to be treated and amount of methadone to be dispensed. *DISAPPROVED*, because the purpose of this bill is already superseded by Federal legislation.

A-144—To establish qualifications for laboratory directors under the Bio-Analytical Laboratory and Laboratory Directors Act in conformity with the Federal standards for such directors in Title 20, Chapter 3, Part 405 of the code of Federal regulations. *DISAPPROVED*, because this bill would lower the standards of existing statutes and would impose a costly regulation system in lieu of the high quality system already adopted in 44 other states.

A-179—To amend the "Health Care Facilities Planning Act"; to provide that no new certificate of need be required when ownership of certain health care facilities is transferred. *APPROVED*

A-181—To remove authority of Commissioner of Health to require reports re operations' costs and service utilization from health care facilities. *APPROVED*

A-193—To provide that firemen or policemen suffering disability or death from a respiratory disease shall be presumed to have been suffered in the performance of duty. *DISAPPROVED*, because it involves diagnosis by legislative enactment rather than by medical evaluation.

A-229—To prescribe that certain publications, listing or communications shall not be deemed advertising by podiatrists, physicians, surgeons, chiropractors and psychologists. *APPROVED*

A-251—To provide for examination of public school pupils suspected of being under the influence of controlled dangerous substances. *APPROVED*

A-262—To amend the law concerning operation of a motor vehicle while under the influence of narcotics to conform to the New Jersey Controlled Dangerous Substances Act. *APPROVED*

A-268—To clarify the State's ability to obtain a credit or refund of payments under the Medical Assistance and Health Services Act where an insurance company is obligated to make medical payments. *NO ACTION*

A-269—To provide that the insurance commissioner may suspend or refuse to renew an insurance license where the holder thereof has forged the name of an applicant, examining physician, witness or any instrument used with an insurance application. *NO ACTION*

A-274—To provide for the regulation of clinical laboratories. *DISAPPROVED*, because of recent amendment to the law (December 18, 1973).

A-285—To require continuing education for registered optometrists in order to qualify for renewal certificates. *NO ACTION*

A-290—To provide that the consent to medical or surgical care by a physician or to services by a public or private hospital or public clinic by a person 18 years or more of age shall be valid and binding. *NO ACTION*

A-326—To permit employees of municipal institutions holding the degree of M.D. or D.O. to apply to the Board of Medical Examiners for exemption from the act concerning the practice of medicine and surgery. *DISAPPROVED*, because MSNJ feels that it is contrary to the public interest to entrust patients to the care of unlicensed physicians other than interns and residents in approved training programs.

A-332—To provide for the Department of Mental Hygiene Act. *DISAPPROVED*, because this bill does not require that the Commissioner of this new department be a physician commiserate with the problems of the mentally ill.

A-356—To provide that any person who operates a motor vehicle shall be deemed to have given his consent to the taking of blood and urine samples for deter-

mining the content of drugs in his system.
APPROVED

A-366—To provide that unless the prescriber explicitly specifies a brand name the pharmacist may dispense the same drug under its generic name if it reflects a lower cost to the customer. *CONDITIONAL APPROVAL*, provided the word "explicitly" is deleted from the bill.

A-390—To provide that any condition or impairment of health to a uniformed member of a paid fire department caused by hypertension, heart disease or tuberculosis shall be deemed to be an occupational disease. *DISAPPROVED*, because it involves diagnosis by legislative enactment rather than by medical investigation.

A-412—To permit qualified technical aides to perform limited medical procedures ordered by a responsible licensed physician. *ACTIVE SUPPORT*

Note: Board referred A-412 to Reference Committee "E" and the House of Delegates, along with the Senate physicians' assistants bills for determination of a policy decision — This directive had already been accomplished by distribution to the House of Supplemental Report #2 of the Council on Legislation.

A-414—To provide that any person arrested on violation of the Controlled Dangerous Substances Act and while on bail is again arrested in violation thereof shall not be privileged to further bail pending disposition of charges. *NO ACTION*

A-466—To provide that an act to cause miscarriage of a pregnant woman is justifiable when committed with her consent by a duly licensed physician acting within 24 weeks of the beginning of the pregnancy or under a reasonable belief such is necessary to preserve her life. *DISAPPROVED*, as written, because the bill is not compatible with the official position of MSNJ adopted by the House of Delegates in May 1972.

A-483—To provide that no licensed chiropractor, not registered to use physiotherapy modalities, shall use such modalities. *APPROVED*

A-504—To prescribe what is a justifiable abortion and to permit physicians, medical personnel and private institutions to refuse to perform an abortion. *APPROVED*

A-536—To provide for the licensing and registration of the practice of massage and to create a Board of Massage Examiners. *DISAPPROVED*, because this bill is not of legitimate licensing interest and further would authorize chiropractors to prescribe a modality which is outside the scope of their license.

A-539—To provide for disclosure of laboratory costs to patients and third party payers. *NO ACTION*

A-677—To require inclusion of "home health care" in health insurance policies covering inpatient hospital care

or skilled nursing facility care; to prohibit total dollar amount limit, separate co-insurance or separate deductible for home health care benefits.
NO ACTION

A-679—To provide for inclusion of home health coverage in hospitalization policies. *NO ACTION*

A-685—To require every restaurant and temporary retail food establishment to have a Department of Health approved device upon the premises intended for use in removing food which becomes lodged in a person's throat. *DISAPPROVED*, because there are alternate methods for this procedure, other than the use of surgical instruments.

A-689—To authorize regional health commissions to grant and regulate licenses and permits incident to health matters. *NO ACTION*

A-730—To provide that any applicant for a medical license in addition to supplying required proofs can show that he has been engaged in a reputable practice for ten years shall be granted a license without further examination upon payment of a fee. *DISAPPROVED*, because it would abrogate the present discretionary powers of the Board to act on the basis of objective evidence and would impose an obligation to make subjective judgments as to what constitutes "proof," "reputable practice," and "conceded eminence and authority in his profession."

A-731—To provide for granting an applicant a license to practice medicine and surgery upon proving that he was examined and licensed by the appropriate body of any foreign country. *DISAPPROVED*, because it would circumvent the orderly and dependable procedure for licensing of physicians adopted by the State of New Jersey as a means of protecting the public against unqualified practitioners. It would impose upon the State Board of Medical Examiners the almost impossible responsibility of ascertaining the standards of licensure applied in all foreign countries, and of deciding whether those standards may be accepted as equivalent to those which New Jersey imposes or to those of other states whose licenses New Jersey accepts on a basis of reciprocity.

A-957—To provide that live vertebrate animals shall not, as part of a scientific experiment, be subjected to vivisection or experimentation and to provide for humane care. *DISAPPROVED*, because it would hinder progress of scientific animal research, with jeopardy to the public welfare.

A-960—To provide for a program of pharmaceutical assistance to the disabled and to appropriate \$750,000. *APPROVED*

A-966—To prohibit smoking in any hospital patient room or patient area, elevator, indoor theater, library, art museum, concert hall, school building, school athletic facility or bus except in areas designated as smoking areas. *APPROVED*

A-967—To require health care facilities to designate not less than 30% nor more than 50% of the total number of

patient rooms as "No Smoking Allowed" rooms. *DISAPPROVED*, in favor of A-966.

A-1011—To authorize first aid and rescue squad workers to display special flashing blue lights on their cars when responding to emergencies. *NO ACTION*

A-1015—To prohibit a physician or surgeon to enter into a contingent fee arrangement in any matter where medical treatment or services are rendered to form any basis of a legal claim for damages or workmen's compensation. *APPROVED*

A-1016—To provide that it shall be a misdemeanor for a physician to charge fees excessively higher than the normal patient fees for services in workmen's compensation or negligence action claims. *NO ACTION*

A-1017—To provide that it shall be a misdemeanor for any physician or surgeon to execute a false medical report which is subsequently submitted to any judicial or administrative proceeding. *ACTIVE SUPPORT*

A-1018—To require physicians and surgeons to provide patients with a true, accurate and itemized copy of the bill for treatment rendered where it will be the basis of a legal claim for workmen's compensation or damages in negligence. *NO ACTION*

A-1049—To remove the requirement that a person must be a citizen of the United States to receive a license to practice medicine or surgery in this State. *NO ACTION*

A-1050—To require the Board of Pharmacy to compile a list of the 100 most used prescription drugs and to require drug stores to post the prices for such drugs. *APPROVED*

A-1051—To delete paragraph R.S. 45:14-12(c) which prohibits the promotion of prices of prescription drugs through any media. *NO ACTION*

A-1066—To permit advertising of retail prices of prescription drugs and to require pharmacy posting of prices of commonly dispensed prescription drugs. *APPROVED*

A-1067—To require the Director of Motor Vehicles to provide a procedure for noting upon a driver's license that the licensee is a donor under the Uniform Anatomical Gift Act. *APPROVED*

A-1068—To permit deposits of documents showing the nature of a gift under the Uniform Anatomical Gift Act with the Director of Motor Vehicles. *APPROVED*

A-1098—To provide that a person who refuses to take the chemical test to determine the amount of alcohol in his blood shall not lose his driver's license unless he is convicted of violation under R.S. 39:4-50. *DISAPPROVED*

Note: Board added the following reasons for disapproval of A-1098 — "in favor of A-356."

A-1115—To provide that no health care facility which is intended to be used or applied to the conduct of abortions shall be operated in any municipality unless a referendum on the question is held at a general election. *DISAPPROVED*, because this bill would discriminate against women desiring abortions and would force them to seek services outside of their community. Additionally, the constitutionality of such a statute is suspect in view of U.S. Supreme Court decisions on this topic.

A-1116—To provide that no health care facility intended to be operated as an outpatient abortion facility shall receive a certificate of need unless it can be clearly demonstrated that the outpatient facility has a written affiliation with one or more hospitals, that there is a procedure for transmitting pertinent clinical information to the hospital and that there is immediately available transportation. *APPROVED*

A-1171—To establish a division of alcoholism in the Department of Health, to create an advisory council, to provide for licensing of alcoholic treatment facilities, to prescribe procedures concerning arrest of an intoxicated person, to authorize establishment of a service force and to repeal and prohibit municipal ordinances prescribing penalties for public intoxication. *APPROVED*

A-1191—To permit preparation of a directory of physicians for consumer use which shall include the educational background, degree, fellowships, certification, specialties, experience and any other pertinent information related to the practice of medicine and surgery of the physicians. *NO ACTION*

A-1205—To require the inclusion of ambulance service benefits in health insurance contracts for services rendered by nonprofit municipal or volunteer first aid squads. *NO ACTION*

A-1216—To create a Rutgers, South Jersey Medical and Dental College Planning Council and to appropriate \$90,000. *DISAPPROVED*, because although the Society has consistently urged and strongly supported establishment of a third medical school in Southern New Jersey as soon as possible, it approved and supported the incorporation of both existing schools — at Newark and Rutgers — under the title of "The College of Medicine and Dentistry of New Jersey" and under the control of one Board of Trustees. We hold that a third school should be under the same corporate title and the same Board's control.

A-1250—To require all group health insurance policies to provide benefits at least equal in value to 60 days hospitalization and \$1,000 or 50% of mental health expenses under major medical coverage. *ACTION DEFERRED*, pending further information from the Council on Mental Health.

A-1251—To require all group hospital service contracts to provide benefits at least equal in value to 60 days hospitalization as a result of mental illness. *ACTION DEFERRED*, pending further information from the Council on Mental Health.

A-1252—To require all group medical service contracts to provide benefits of at least \$1,000 or 50% of mental health expenses under major medical coverage. *ACTION DEFERRED*, pending further information from the Council on Mental Health.

A-1381—To require a treating physician to notify the local board of health when a patient with tuberculosis in a communicable form leaves a hospital against the advice of the physician. *APPROVED*

A-1404—To permit municipal hospitals to employ on a salary basis physicians who do not hold New Jersey licenses. *DISAPPROVED*, because MSNJ feels that it is contrary to the public interest to entrust patients to the care of unlicensed physicians other than interns and residents in approved training programs.

A-1425—To provide certification as an x-ray technician for Gabrielle Smith Weinstein. *DISAPPROVED*, because this bill is in violation of our position on A-1490. Also, this bill would set a dangerous precedent for other non-trained individuals.

A-1432—To provide medical study scholarships for students agreeing to practice medicine in areas designated as having a shortage of physicians. *APPROVED*

A-1450—To repeal the "Right to Know Law" (P.L. 1963, Chapter 73) and to appropriate \$100,000. *NO ACTION*

A-1453—To amend the act to regulate the practice of ophthalmic dispensing. *ACTION DEFERRED*, pending further information from the New Jersey Academy of Ophthalmology and Otolaryngology.

A-1455—To amend the "New Jersey Medical Assistance and Health Services Act," to increase criminal penalties and to provide for recovery of excessive reimbursements. *DISAPPROVED*, because this bill would create a criminal act without criminal intent.

A-1458—To permit advertising of retail prices of prescription drugs. *APPROVED*

Note: Board amended Council's position of "no action" to "approved."

A-1459—To add a second public member to the 19 professional and occupational boards. *APPROVED*

A-1490—To provide that any person who knowingly employs an x-ray technician who requires and does not possess a valid certificate shall be guilty of a misdemeanor. *APPROVED*

A-1538—To permit ophthalmic dispensers and technicians to advertise. *ACTION DEFERRED*, pending further information from the New Jersey Academy of Ophthalmology and Otolaryngology.

A-1540—To provide uniform enforcement powers and procedures and uniform standards for revocation, suspension and other disciplinary sanctions for professional and occupational boards within the

Division of Consumer Affairs. *DISAPPROVED*, because rather than creation of a new system, effective staffing and funding of the present system are indicated.

A-1575—To provide that it shall be a misdemeanor for any physician or surgeon to falsify intentionally any medical report used in workmen's compensation, negligence cases or any other type of legal proceeding. *APPROVED*

A-1615—To require pharmacists to list drugs and medicines by generic names and permit them to substitute brand names for the same prescribed-named drug with the consent of the doctor if it reflects a lower cost to the consumer. *APPROVED*

A-1629—To require sampling and testing of semi-public water supply systems by local boards of health. *APPROVED*

A-1659—To require females to take serological tests, prior to issuance of a marriage license, to determine if they ever had rubella. *ACTION DEFERRED*, pending further information from the Council on Medical Services.

A-1662—To regulate the collection, maintenance and dissemination of personal information by agencies maintaining data systems under a "Right to Privacy and Fair Information Practices Act." *NO ACTION*

A-1714—To define "private nursing facility" and to permit the Commissioner of Health to make reasonable exceptions or waivers from his rules and regulations governing nursing homes. *NO ACTION*

A-1718—To provide for the inclusion of benefits for the treatment of alcoholism in hospital service corporation contracts. *APPROVED*

A-1719—To provide for the inclusion of benefits for the treatment of alcoholism in group health insurance contracts. *APPROVED*

A-1720—To provide for the inclusion of benefits for the treatment of alcoholism in medical service corporation contracts. *APPROVED*

A-1722—To provide for the inclusion of benefits for the treatment of alcoholism in health insurance contracts. *APPROVED*

A-1733—To appropriate \$600,000 to the Department of Higher Education for the South Jersey Medical Program. *ACTIVE SUPPORT*

A-1813—To provide that an applicant is eligible to take the State medical examination if he has completed undergraduate pre-medical training in an accredited American college or university and has completed, in a foreign medical school recognized by the World Health Organization all the formal requirements of the school except a foreign internship and has completed 12 months of clinical training. *DISAPPROVED*, because it would admit to examination physicians who have not com-

pleted an internship and whose clinical training is currently recognized as being deficient.

A-1827—To remove the licensing requirement for ophthalmic technicians. *ACTION DEFERRED*, pending further information from the New Jersey Academy of Ophthalmology and Otolaryngology.

A-1864—To prohibit physician charges for surgery or related services in excess of the patient's health insurance coverage if the patient is totally incapacitated, mentally retarded, physically handicapped, a welfare recipient, on social security or covered by Medicaid or Medicare. *DISAPPROVED, WITH ACTIVE OPPOSITION IF THE BILL MOVES* because the bill violates the physician's constitutional right to contract for his services either directly with his patients or with a given hospital. Further, it is violative of the civil rights of physicians and patients. Finally, it makes little or no sense from an economic viewpoint. The mere fact that a patient is physically or mentally handicapped receiving social security payments or covered by Medicare bears no correlation to the economic resources of the individual. Millionaires and multi-millionaires could and do fall in each and/or all of the above categories.

A-1869—To include services of veterinarians and veterinary hospitals among those which can be financed through retail installment sales contracts. *NO ACTION*

A-1877—To provide workers' compensation coverage for student teachers and student nurses. *NO ACTION*

A-1881—To provide for local health purposes that State equalization aid shall be the amount per capita of the population in the area of jurisdiction, shall not be less than 50% of the capitation amount provided in the General Appropriation Act and to provide that capitation shall be \$2.50. *NO ACTION*

A-1898—To provide a subscriber, or covered dependent, under medical service corporation plan including medical services rendered by a licensed chiropractor. *ACTIVE OPPOSITION*, because the services which chiropractors are licensed to provide are not among the services covered by medical service corporations. They are not licensed or recognized as physicians or surgeons and are not qualified — or licensed — to supply medical and/or surgical services for injuries and/or disease conditions.

... Noted the following bills and directed that they be filed as not being of concern at this time:

SCR-126—To memorialize Congress to protect the Medicaid Program from abuses from unreasonable transfers of assets by persons seeking eligibility.

A-1437—To require the Commissioner of Health to issue a health officers' license to a duly licensed physician or surgeon with at least 25 years of medical practice and at least 10 years' experience as Director of

the Health Department in cities with population of more than 60,000 inhabitants.

A-1874—To provide various amendments to the act concerning insurance relating to variable contracts.

AJR-21—To establish a commission to conduct a study and make recommendations to the Legislature concerning the standards for the determination of death.

ACR-6—To create a commission to study the feasibility of establishing programs of pre-school training for physically handicapped children.

ACR-13—To create a commission to study the procedures for licensing persons engaged in the medical, dental, and nursing professions, the shortage of adequate numbers of health care personnel and to consider the need for retesting.

Professional Liability Insurance ... Approved the following suggestion of the Executive Director:

(a) That the Society promptly should notify both Chubb and the State Insurance Department that the Executive Director and James E. George, M.D., J.D., are the attorneys of record in all matters pertaining to The Medical Society of New Jersey's professional liability insurance program.

... Noted that action had been taken previously on the following (4/25/76 meeting of the Board, reported in the June 1976 issue of *JMSNJ*, p. 540):

That MSNJ support the balance of the filing, i.e., changes in classification and rate distribution ratios.

... Approved the following suggestions of the Executive Director:

(b) That during the hearing and negotiations, MSNJ maintain the posture that Chubb is bound to write the program as long as adequate rates are available. The obligation of the Department is to approve "adequate but not excessive rates" and the question therefore is really between Chubb and Mr. Sheeran.

(c) That should Mr. Sheeran evolve a decision not acceptable to Chubb, MSNJ oppose activation of A-1552. If it is invoked, MSNJ maintain that the rates cannot exceed any rate disapproved by Mr. Sheeran as excessive.

(d) That MSNJ should place a September 15 deadline on both parties. Should the matter not finally be resolved by September 30, MSNJ should file immediate suit naming Chubb and the Insurance Department as co-defendants.

Medicare Fees ... Approved the following recommendation (amendment by the Board indicated by italics) from the Council on Medical Services:

That the Board of Trustees prepare an emergency resolution in reference to Medicare which will be presented to the AMA, JEMPAC, AMPAC, HEW, and the members of the U.S. Senate and House of Representatives from New Jersey in reference to the need for input and opinions in reference to the resolution submitted by Representative Rostenkowski, and that MSNJ is in agreement with this resolution. Further, that any input or opinions be submitted as soon as possible as this resolution must become effective by July 1, 1976.

Note: Following the close of MSNJ's Annual Meeting, the Legislative Attorney of the AMA Washington Office informed MSNJ that the AMA already has taken a position in favor of Mr. Rostenkowski's proposed legislation. Thus, the introduction of a resolution to the AMA is unnecessary.

Payment by Blue Shield for Consultation in Consultant's Office . . . Agreed that Charles L. Cuniff, M.D., be invited to attend the July meeting of the Board of Trustees to discuss Resolution #30 (which recalls Resolution #11 of the 1974 House, referred to the Council on Medical Services) of the 1975 House of Delegates which had been rejected; however, the House had directed that the subject be considered by the Council on Medical Services and representatives of Blue Cross-Blue Shield. It was noted that the suggested program would carry potential for abuse and that some type of pilot program would be desirable.

CME Requirements — Exemptions . . . Received as informative a statement from Dr. Bernstein that it was within the power of the Committee on Medical Education to institute a policy to grant a six-month extension to physicians failing to comply with the continuing medical education requirement for the first three-year period, to be implemented as of June 1, 1976. (See subsequent action of House of Delegates, page Tr 105, this issue.)

Temporary and Limited Licensure . . . Referred a letter, drafted (in accordance with Board action of 5/16/76) by Drs. Rogers and Bergen concerning MSNJ's concepts on temporary licensure, to the Executive Committee for consideration.

Board of Medical Examiners' Nominees . . . Directed that the name of William Pomerantz, M.D., be submitted as a nominee to the State Board of Medical Examiners and that the Executive Committee select two other physicians also to be placed in nomination.

June 8, 1976

Introduction of New Members . . . Welcomed Dr. Anthony P. DeSpirito, 4th District, and Dr. Armando F. Goracci, 5th District, newly elected members of the Board. . . . Presented Dr. Alfred A. Alessi, newly elected Second Vice-President.

. . . Noted that Dr. Arthur Bernstein was re-elected to the office of Secretary and that Dr. Rudolph C. Gering was re-elected to the office of Treasurer.

Reorganization of the Board . . . Re-elected Dr. James S. Todd as Chairman and Dr. Edward G. Bourns as Secretary of the Board for 1976-1977; agreed to continue meeting regularly at 10 a.m. on the third Sunday of each month in the Executive Offices (subject to cancellation if the agenda proves insufficient).

Investigation of Pharmacies . . . Agreed, upon request from the State Board of Medical Examiners, to provide the names of physicians willing to provide prescriptions for drugs (to be used as part of an investigatory procedure covering pharmacies suspected of violating statutes regarding the dispensing of drugs) by having the personnel of the Board so serve.

Note: The Board members were advised that, for legal purposes, when called upon by the State Board to supply prescriptions, the physician should obtain a receipt.

Guests at Board Meetings . . . Agreed to continue the policy of inviting presidents of specialty societies and component societies to meetings of the Board of Trustees and voted to expand this policy to include presidents-elect and executive secretaries/directors of component societies.

. . . Directed that an attendance sheet of specialty society representatives and county society representatives be kept and made available for review by the Board.

Admission of Osteopathic Physicians to The Medical Society of New Jersey (Resolution #1):

RESOLVED, that the Board of Trustees form a committee to investigate the legal, practical, and actuarial consequences of admitting osteopathic physicians to join The Medical Society of New Jersey. The Committee shall report to the House of Delegates at its next regular meeting the ad-

visability of accepting osteopathic physicians into the membership of The Medical Society of New Jersey.

... Authorized the President to appoint a committee for the purpose set forth in Resolution #1

Assurance of Professional Competence (Resolution #2):

RESOLVED, that The Medical Society of New Jersey emphasize the expulsion and delicensure of those physicians in our midst who would defame the good name of our honored profession; and be it further

RESOLVED, that this resolution be introduced, in suitable form, for adoption by the AMA House of Delegates at its Dallas, 1976 meeting.

... Referred Resolution #2 to the New Jersey Delegation to the AMA for preparation of an appropriate resolution.

High Fees for Participation in Continuing Medical Education Programs (Resolution #23):

RESOLVED, that The Medical Society of New Jersey is opposed to charging a participant a fee in excess of the reasonable cost of providing the educational program; and be it further

RESOLVED, that the sponsoring agency be required to indicate whether it is a profit or non-profit educational endeavor; and be it further

RESOLVED, that the New Jersey Delegation to the AMA be instructed to introduce the above resolution at the AMA meeting in Dallas.

... Directed that the first two "Resolves" be

referred to the Committee on Medical Education and that the New Jersey Delegation to the AMA be instructed to prepare an appropriate resolution for presentation to the AMA House of Delegates in June 1976.

Exemption from Continuing Medical Education Requirements (Resolution #28):

RESOLVED, that the actions taken by the Board of Trustees of MSNJ, as published in the *Membership Newsletter* No. 248 (April, May 1976) "Guidelines for Exemptions from Continuing Medical Education," paragraph (e) — wherein such members are to be granted a three-year extension — be abrogated by this House of Delegates and that exemptions for reasons other than poor health, age, or infirmity be denied.

... Directed that Resolution #28 be referred to the Standing Committee on Medical Education.

Annual Meeting ... Approved a request from the Chairman of the Committee on Annual Meeting, Dr. James E. D. Gardam, that the Committee be authorized to poll those delegates in attendance at the 1976 Annual Meeting as to their preference for a meeting location.

Note: Dr. Gardam stated that he plans to explore all possible meeting sites and report the Committee's recommendations to the Board.

... Commended Dr. Gardam and his Committee for their efforts toward a successful 1976 Annual Meeting.

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William Arthur Smith is offering an edition limited to fifty signed original impressions from the wood blocks of the bicentennial cover of *The Journal*. They are done on handmade Mariki or mulberry fiber papers (which are particularly adaptable for wood cuts) in black, gray, and a subdued red. Each proof requires three baren-rubbed hand printings.

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Published monthly (since 1904), under direction of the Committee on Publication, by The Medical Society of New Jersey, 315 West State St., Trenton, N.J. Printed in Hanover, New Hampshire by the Dartmouth Printing Co. Whole number of issues 865. Member's subscription (\$5) is included in Society dues. Rates for nonmembers, \$10; outside USA add \$2.50 for postage. Single copies, \$1. Address communications to *The Journal*, MSNJ, P.O. Box 904, Trenton, N.J. 08605 (609) 394-3154. Second class postage paid at Trenton, N.J. and additional entry office. Copyright 1976 by The Medical Society of New Jersey.



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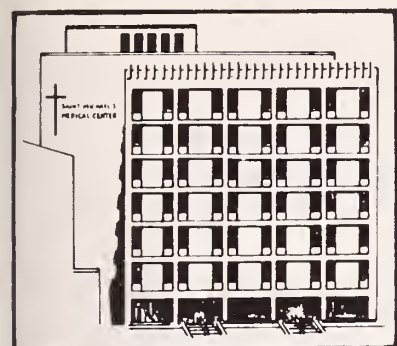
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THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original FDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only the cost of the lowest-priced, purportedly-equivalent,

generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than \$1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

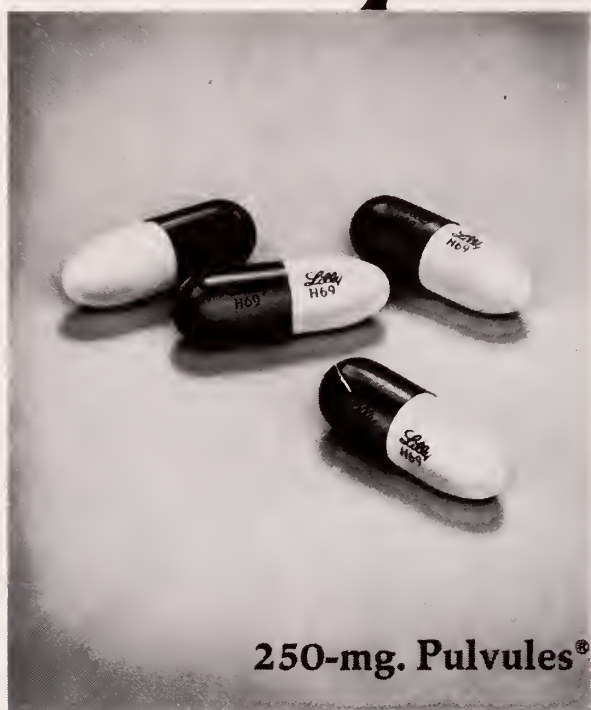
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EDITORIALS

New Jersey — The Cancer State?*

With the release of the National Cancer Institute's report on mortality, some representatives of the media had their usual heyday labeling New Jersey as "Cancer Alley" and "The Cancer State" instead of "The Garden State." The result was embarrassment for the state government, the health department, and other state departments, bureaus, and agencies. Should The Medical Society of New Jersey, hospitals, individual physicians, and health centers feel guilty and be subject to criticism? How about New Jersey industries — are they the culprits? Is it really that easy?

One must "look at the facts" if he is to have a sensible opinion on the matter of what is behind all of this. The report stated that:

1. New Jersey has the highest overall cancer mortality in the United States.
2. New Jersey has the highest cancer mortality for white males.
3. New Jersey has the second highest cancer death rate for white females.
4. New Jersey ranks fifth in the nation for non-white cancer mortality.
5. Virtually every county in our state has mortality rates in excess of the nation, for each category, and is in the top decile nationally.
6. By organ site, New Jersey leads the nation in cancer of the bladder and urinary tract, and is among the pacesetters in cancer of the esophagus, stomach, large intestine, upper and lower respiratory tract, and breast.
7. Peculiarly, non-white females in New Jersey have the highest rate of cancer of the rectum in the country; our state's white females are first for cancer of the ovary, fallopian tube, and broad ligament.
8. Non-white females are number two and non-white males are number three for bone neoplasms in the United States.

Since these data come from death certificates and not from a statewide cancer registry, it is not necessarily a commentary on diagnosis and treatment. There are some penetrating questions that evidence such as this raises.

What role does industrial intoxication play in our densely populated state?

The relationship between bladder cancer and beta-naphthylamine (as in Salem County) and that between vinyl chloride production and angiosarcoma of the liver are undoubted. The majority of lung cancers, however, are not apparently industry-related but due to cigarette smoking. All in all, it appears that industry may be responsible for some, but not, by any means, for all of the high cancer mortality in New Jersey.

If not industrial intoxication, what are the causes? Genetic and immunologic factors may play a role, while viruses may be provocative also. Other unknown environmental stresses are probable stimulants of individual cancers as well. There are more questions:

1. Why should non-white women in New Jersey have so many rectal cancers and bone neoplasms?
2. Why should white females in our state be so inflicted with cancer of the ovary?
3. Why is there so much cancer in the thirteen northern counties of New Jersey?
4. Why is breast cancer so frequent in the counties bordering New York City and Philadelphia?
5. Why does Hudson County have double the U.S. mortality rate for cancer of the esophagus?

Like much research, the results lead to more questions than answers. It is quite clear, however, that the answer to these questions — and others — rests in epidemiology, the study of cancer "among the people." It is also clear that a meaningful attack on cancer in New Jersey will require:

- organizationlots of it
- moneylots of it
- cooperationlots of it
- enthusiasmlots of it

The "team" in this fight must be federal and state government; organized medicine and individual physicians; hospitals, health agencies, and all types of health professionals; educators; voluntary health agencies; third party payers; industrial management and unions; and, most of all, a forewarned citizenry. A.K.

*See related article, page 749, this issue. A second report, prepared by the State Department of Health, will appear in the October issue, JMSNJ.

Newspaper Writers: Craftsmen or Captives?

(A letter to Mr. Warren E. Leary of the Associated Press)

The headline of your AP release which was published in the *Sunday Times Advertiser* (Trenton, N.J.) on June 20, 1976, blared:

**"DIABETES MEDICINE CONTAINING
CANCER AGENT BEING REPLACED."**

The article said that the Upjohn Company "is quietly replacing stocks of a widely used oral diabetes treatment because the drug (Tolinase®) contains minute amounts of a cancer-causing chemical." You went on to relate that a Food and Drug Administration spokesman said "the amount of chemical contaminant was so small that it posed no immediate health hazard and a formal recall was considered unnecessary."

Your information came from a Ralph Nader letter charging "a secret agreement between FDA and Upjohn to withhold from the public news of a potential health hazard." Dr. Sidney M. Wolfe, of Nader's Health Research Group, claims the contaminant chemical, a nitrosamine, caused cancer in rats and hamsters.

Dr. J. Richard Crout, Director of FDA's Bureau of Drugs, responded that Wolfe's charge, "is without foundation and irresponsible" and went on to say: "The amount of nitrosamine in the old product consumed daily by a patient taking the maximum dose of Tolinase® would be thousands of times smaller than the dose that causes cancer in rodents." He further said that "the FDA does not notify the public of manufacturing changes for drugs when no health hazard or violation of law is involved. Patients now taking Tolinase® should not disrupt their therapeutic programs."

Mr. Leary, do you realize that your article and its headline confused and upset thousands of nice people. These consumers have enough trouble with diabetes and they don't need this unnecessary anxiety. This kind of so-called "public information" does not *inform* anyone! It is better called "public aggravation" — and we have enough of that! Reporters never stop reminding us that our air and water are polluted, our food and drugs are unhealthy, our cars and airplanes

are dangerous, our children can't read and their SAT scores are dropping, and our government officials are corrupt, sex-mongers who jump in and out of bed with partners of either sex and do little else but steal our tax money, while they spend the rest of their time drinking whiskey, taking drugs, and trying to get re-elected. Journalists have falsely labeled some ordinary drugs as "miracles" and good medications as poison. And always you duck behind the Constitution when someone questions your accuracy or your motives!

Mr. Leary, are you newsmen in cahoots with the Naders and the Wolfes? Don't you try to evaluate the source, accuracy, and authenticity of material — even to the slightest degree — before you write it as fact? A professional in your craft ought at least to reread his piece and consider the potential harm it may do to its "consumers."

Did you know that Geri Joseph, a colleague of Ralph Nader, had published a critical open letter to "Ralph" in which he spoke of "inaccuracies and sloppy work," presumably by Nader's "13 subsidiary groups"? Joseph also said that a lot of people think that Nader is needling the medical profession "with too big a needle" in his accusations of "too many unnecessary operations, too many unnecessary prescriptions" and "unsatisfactory care by doctors." Do you cater to Nader because you are afraid he may go after newsmen next? He may, you know, if you start to criticize him.

Mr. Leary, it looks as though writers like you have capitulated to the self-appointed "consumer advocates," who act more like consumer aggravaters. You don't seem to do your own thinking — but simply parrot the nonsense that these people hand you, add on an irrelevant but shocking headline, and then turn your back on the end-product. Your craft is the loser in this kind of writing. And, your readers are losers. And, worst of all, you lose your credibility! Think about it, Mr. Leary. Are you your own man or do you belong to the Wolfes and the Naders?

A.K.

N.B. The headline should have said:

**"FDA ADVISES DIABETICS NOT TO
DISRUPT TREATMENT."**

When **impotence** due to
androgenic deficiency

is driving them apart



Android[®]-5 Buccal
Tabs
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Tabs
Android[®]-25 * Oral
Tabs

Methyltestosterone N.F. — 5, 10, 25 mg.

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-7-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and hypogonadism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-pubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and hypogonadism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpubertal cryptorchidism, 30 mg. **REFERENCE:** Robert * B. Greenblatt, M.D., and D. H. Perez, M.D.: "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Vitamin D	250 U.S.P. Units
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Ascorbic Acid	25.0 mg
Folic Acid	0.1 mg
Vitamin B-12	1.5 mcg

Methionine	12 mg
Choline Bitartrate	15 mg
Inositol	10 mg
Calcium Pantothenate	2.5 mg
Pyridoxine	0.25 mg
Copper (from Copper Sulfate)	0.25 mg
Zinc (from Zinc Oxide)	0.25 mg
Iodine (from Potassium Iodide)	0.075 mg
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*

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"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium® (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

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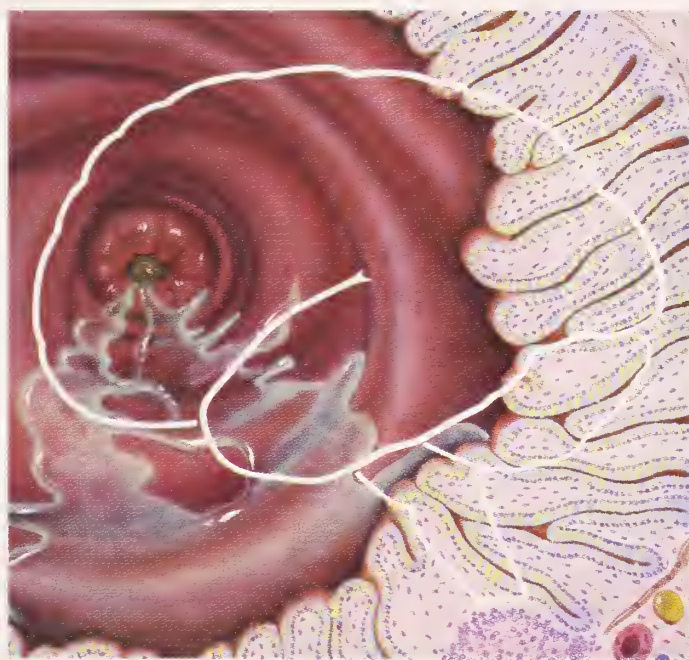
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Methanol is an important health hazard. It can be absorbed by ingestion and inhalation and also through the skin. The cardinal clinical manifestations of methanol intoxication are visual difficulties, metabolic acidosis with a significant anion gap, and a measured osmolality significantly higher than that calculated by the usual formula. The toxicological effects are due to the breakdown product, formaldehyde, rather than to the parent substance, methanol, or to the higher oxidation product, formate. With a history of potential or actual exposure it becomes imperative to treat the patient immediately. The specific measures to be used (administration of NaHCO_3 , and ethanol and hemodialysis) are discussed and the course of a patient who voluntarily ingested both formaldehyde and methanol and who recovered completely is briefly recorded.

Methanol Intoxication: Biochemical and Clinical Aspects*

**Francis P. Chinard, M.D., and
Wilhelm R. Frisell, Ph.D./Newark**

Metabolic acidosis occurs most frequently in patients with diabetes mellitus or severe renal disease. It can be drug-induced as in the lactic acid acidosis associated with phenformin administration. It can also be produced by normal metabolic action on an abnormal substrate. Typically, that situation occurs following the ingestion of methyl alcohol or methanol.

The patient's story which follows is used mainly as an introduction to a discussion of methanol and its toxic effects in human beings. Although sorely stressed, the patient survived with transient loss of some gastric mucosa and some localized thrombophlebitis but without apparent long-term ill effects.

The Patient's Story and Course

In the early morning hours the patient, a 22-year-old female, probably intoxicated with ethanol, got into an argument with her boy friend and in a suicide gesture drank about two ounces (approximately 60 ml) of embalming fluid containing about 27 percent of formaldehyde and an unknown but large percentage of methanol. She vomited promptly and was brought to the emergency room where her stomach was washed out. The maximum amount of methanol that she could have ingested was $60 \text{ ml} \times 0.73$ or 43.8 ml of methanol (approximately 35 grams or slightly more than one mole of methanol).

In the emergency room, arterial blood analysis showed: pH 7.18, $[\text{HCO}_3^-]$ 9.5 mM/L, Pco_2 26.6 mm Hg, Po_2 128.9 mm Hg.

Because methanol intoxication was the most likely diagnosis, gastric lavage was started almost immediately and 88 mEq

of sodium bicarbonate was given intravenously. This amount would have resulted in an increase of extracellular fluid (ECF) bicarbonate concentration of not more than 8 mEq/L. (That calculation is based on a body weight of approximately 55 kg with ECF estimated to be 20 percent of body weight.) In the next few days, however, she received substantial additional sodium bicarbonate by nasogastric tube because of esophagitis and gastritis. Her CO_2 content rose to 37.0 mEq/L while the $[\text{Cl}^-]$ and $[\text{K}^+]$ decreased to 93 and 3.0 mEq/L respectively. Arterial blood during this period showed pH values of 7.53 to 7.60. She was presumably absorbing the bicarbonate being given by tube.

Hemodialysis was started within two hours of her admission. She was given 500 ml of five percent ethyl alcohol in 0.9 percent sodium chloride intravenously. Fever was present for a few days but no bacterial etiology was determined. An anemia, which was thought to have been due to bleeding because of erosive gastritis, responded to parenteral iron administration. No visual disturbances were reported or detected at any time, and her course was otherwise relatively uneventful. Having been a drug user since age 12, she was seen several times by the staff of the psychiatry service and was provided with the opportunity of entering a drug detoxification program.

Epidemiology of Methanol Intoxication and Abuse

Methanol intoxication is one of the gifts of an industrialized society. Obtainable in the destructive distillation of wood, as wood alcohol, it is usually accompanied by so many revolting smells that the most confirmed toper in his worst moments of desperation would be unlikely to drink it and if he did drink it, would likely vomit it back up. The pure material, which is readily

*This article is from the Departments of Medicine and of Biochemistry, New Jersey Medical School, CMDNJ, and is based on a Grand Rounds session at the Martland Medical Center, Newark.

available commercially, is as distinctive in appearance, odor, and taste as the better vodkas and has been responsible for many deaths and many cases of blindness. Usually this has occurred in times of scarcity of the usual ethanol-based products, that is, in times of prohibition and of war.

One of the best accounts of these aspects is in Røe's monograph¹ in which is mentioned a 1904 account of 153 cases of blindness and 122 deaths in the United States due to consumption or inhalation of the vapors (see also the report by Tyson² on this latter aspect). Røe also mentioned a report of some Russian soldiers during the Russo-Japanese War who, for want of vodka, drank so-called Kuntzenbalsam, a solution of vegetable oils in methanol. Røe's own encounters with methanol intoxication were in Norway during the occupation in World War II. A major epidemic occurred in this country about 20 years ago and is reported in the classic review by Bennett and others.^{3a}

In that catastrophe, some 90 gallons of "untaxed white lightning" were distributed throughout Atlanta over a short period of time. Later analysis showed that this contained 35 to 40 percent methanol and only four percent or less ethanol. Of the 323 drinkers who were identified (another 100 or so were known to have ingested some of the material) 41 died. What follows is derived from that report and from other sources. A more recent report from Kentucky describes a limited outbreak in which the victims drank shellac thinner.^{3b}

Dosage

There is an enormous variation in the amounts required to produce effects or to cause death. The maximum ingested appears to be about 1.3 liters of 40 percent methanol by some Russian workers. The report by Bennett, *et al.*^{3a} cites a survivor who ingested 500 ml of 40 percent methanol. The smallest reported amount, again in Bennett's review, was about 15 ml of 40 percent methanol. This resulted in a fatality. *The amount ingested by the patient whose story is presented may seem small but is in the range that has been associated with fatalities.* In addition to methanol, our patient was at further risk

because she ingested formaldehyde, the probable toxic intermediate of methanol metabolism. Ammonium acetate, which is recommended for gastric lavage in formaldehyde ingestion, was not available at the time of the patient's admission.

Route of Entry

In most reported cases, as in our patient, the methanol is ingested. However, as pointed out by Skinner⁴ and others,^{3a,5} methanol also can be absorbed through the skin and as a vapor through the respiratory tract. That route of entry had been a matter of concern half a century ago. Although industrial plants may exercise due caution in the production and handling of methanol, such precautions are not necessarily followed by the end-users who strip paint from furniture in enclosed spaces or who attempt to de-ice windshields with sprays of solutions containing methanol. Frosting on the inside may result and the motorist may be tempted to spray the windshield on the inside. This could lead to substantial exposure to methanol vapor in a car with a defroster going full blast.

With regard to the inhalation of the vaporized material, methanol has a low boiling point and *probably* is absorbed completely by the mucous membrane of the upper respiratory passages and tracheobronchial tree rather than at the level of the alveoli. This is a deduction based on the absorption of vaporized labeled water.^{6,7,8} We know of no direct data on this possibly important point with respect to methanol.

Distribution and Handling of Methanol as Such

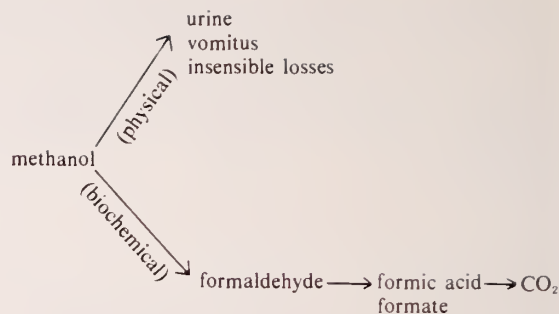
A water soluble alcohol, methanol distributes itself in total body water.⁹ Its passage through an organ and its pathway through cell membranes may however be different from that of water although the volume of distribution may be nearly identical to that of water. Studies carried out in the dog indicate that the diffusion coefficient of methanol in kidney tissue, for example, is greater than that of water because methanol has access to cells across hydrophobic portions of barriers to an extent not available to water.¹⁰ Thus, the permeability of cell barriers to methanol may be greater than that of water. A

possibly significant reflection coefficient for methanol in isolated perfused lung preparations, at temperatures of the order of 15°C, has been detected substantiating the hypothesis of a lipid pathway for methanol across cells.¹¹ However, at normal body temperatures, the reflection coefficient appears to be zero and this fact is of significance in the hemodialysis procedures used to rid the body of methanol. Osmotic balance is unlikely to be significantly disturbed by the rapid removal of methanol from extracellular fluid in contrast to what happens when urea is removed very rapidly as in hemodialysis. Usual avenues of excretion of methanol are the expired air, which over a period of 48 hours, can account for 2 percent or more of the amount ingested, and the urine, from which some 10 percent may be recovered in a similar period. Adequate data are not available but older reports^{12,13} suggest that the excretion of methanol should be closely dependent on the rate of urine flow and relatively independent of glomerular filtration rate (GFR) and of renal blood flow. This suggestion finds support in the report by Kane and his associates^{3b} which provides data permitting comparisons of water and methanol clearances (the former as given by the urine flow). The clearance ratio ($C_{H_2O}/C_{\text{methanol}}$) averaged 1.18 with a standard deviation of 0.49 over a range of urine flows from 0.83 to 8.33 cm³ min⁻¹. Thus increasing urine flow should of itself result in increased excretion of methanol.

Although the distribution of methanol is considered to be the same as that of water, the concentration of methanol is not necessarily uniform throughout the body, when the concentrations in the blood are changing rapidly. Thus, Bennett and his collaborators³ found generally higher concentrations of methanol in the cerebrospinal fluid than in blood in the patients while the blood concentrations were declining. There is no evidence, however, to suggest that methanol is actively concentrated in the central nervous system or in the cerebrospinal fluid.

Clinical Metabolic Aspects

The overall pathways for the disposition of methanol are indicated in the following scheme:



These have been extensively reviewed by Røe¹⁴ and by Cooper and Kini.¹⁵ From the clinical standpoint, the major "biochemical" changes noted are severe metabolic acidosis and a substantial anion gap. An "osmolal" gap may also be present depending on the amount of methanol ingested.

(1) *Acidosis*: This is characterized by a decreased bicarbonate concentration and is a feature uniformly found in patients with methanol ingestion. In Bennett's series, CO₂ combining power values (approximately equal to the bicarbonate concentration) were as low as 4 to 5 mEq/L. In a more recent report,¹⁶ [HCO₃⁻] concentrations were in the 4-10 mEq/L range; pH values were mostly below 7.2 initially and reached a low of 6.96. Values for P_{CO₂} were all reduced below 27 mm Hg and some were reported as low as 8 mm Hg. The patients were hyperventilating but despite this the respiratory adjustment was insufficient to provide complete respiratory compensation for the metabolic acidosis.

(2) *Anion Gap*: In these patients, there is generally a substantial anion gap.^a It cannot be due to the presence of formaldehyde, the first oxidation product of methanol in the simplified metabolic scheme, because it is uncharged. It may be noted, however, that formaldehyde has the potential for generating hydrogen ions in the so-called formaldehyde titration.⁷ It would be reasonable to consider formate, the next step in oxidation to be the major contributor to the anion gap. It is clear, however, that formate itself does not account for the whole of the anion

^aCalculated as $([Na^+] + [K^+]) - ([Cl^-] + [HCO_3^-])$.

gap. An increase of lactate has been demonstrated in several studies. Lactate may play a major role in the severely hypoxic patients or in hyperventilating patients, but adequate information is lacking. Van Slyke and Palmer,¹⁸ in an early report, demonstrated the excretion of formate, lactate, β -hydroxybutyrate and other undetermined organic acids in the urine of a patient who recovered from methanol intoxication. (See also the report by Harrop and Benedict.¹⁹)

(3) *Osmolal Gap*: The osmolality of serum, π'_s , can be calculated from the expression: $\pi'_s = 2 ([Na^+] + [K^+]) + \frac{\text{Glucose}}{18} + \frac{\text{BUN}}{2.8}$ where $[Na^+]$ and $[K^+]$ are determined in plasma or serum by flame photometry and where the glucose and BUN concentrations are expressed in mg per deciliter of plasma, serum, or whole blood. Determination of the serum osmolality by measurement of the freezing point of serum or plasma may show values for the true serum osmolality, π_s , considerably higher than those calculated in the presence of substantial absorption of methanol. For example, the absorption of two moles, or 64 grams, of methanol would give an increase of osmolality of about 67 mOsm/kg of water in a 60 kg patient with a total body water of 50 percent of body weight.

Symptomatology

The development of symptoms specifically referable to methanol toxicity depends on a number of factors, probably the most important of which is the concomitant ingestion of ethanol.

Ethanol interferes with the metabolism of methanol.^{5,20,21,22} The latent period for the development of symptoms may be quite short, a few hours, following the ingestion of *pure* methanol. It may be a matter of 12 hours or more in individuals who have simultaneously ingested ethanol and may be even more prolonged in others who are continuing the ingestion of ethanol. Part of the treatment of methanol intoxication is to keep the patients sufficiently saturated with ethanol to allow for the non-metabolic disposition of methanol and thus to avoid the toxic effects of its metabolites. This point must be stressed — unfortunately, Bennett and his collaborators³ came to the erroneous conclusion that ethanol was not clearly indicated in methanol intoxication.

In any case, it is evident that onset of symptoms and the symptomatology are *not* simply dose-related but depend on other factors. Major manifestations are as follows:

Visual disturbances:^{23,24} This is virtually a universal complaint, which appears as blurring or indistinct vision, "skim" over eyes, snowstorm, and flashes. Regrettably, blindness is a frequent occurrence, but it may be transient, with full recovery or with some residual impairment.

Headache and dizziness

Gastrointestinal symptoms: Nausea and vomiting.

Pain: Epigastric, usually diffuse and sometimes extremely severe.

Dyspnea: Not a frequent complaint. In Bennett's series, Kussmaul-type respirations were not a prominent feature even with marked reduction of $[HCO_3^-]$.

Physical findings: General examination usually shows nothing typical. Some patients have been reported to show a "ruddy cyanosis," but cyanosis has not been a prominent feature in other series. Vital signs show nothing specific.

Eyes: Dilated, non-reactive pupils. Ophthalmoscopic examination shows hyperemia of the optic disc, retinal edema along the course of the major vessels associated with engorgement of the retinal veins. Optic atrophy and visual field defects develop later.

Cardiovascular: Blood pressure appears to be maintained. There are few data on blood flow to various organs. Acute renal failure does *not* appear to be a complication with a significant incidence. Cerebral blood flow is somewhat decreased²⁵ but since the P_{CO_2} is frequently decreased because of attempts at respiratory compensation of the acidosis, this finding is not necessarily due to a specific effect of methanol.

Abdominal examination: Along with the pain in the epigastric region, there is frequently encountered rigidity and tenderness.

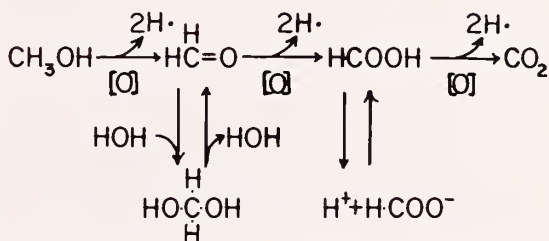
Neurologic examination: Nuchal rigidity has been reported.

Mode of death: Respiratory failure.

Major sequelae in survivors: Visual impairment or blindness.

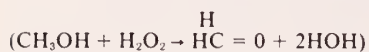
Metabolic Pathways of Methanol Disposition

The oxidation of methanol to carbon dioxide requires the equivalent of three dehydrogenations:



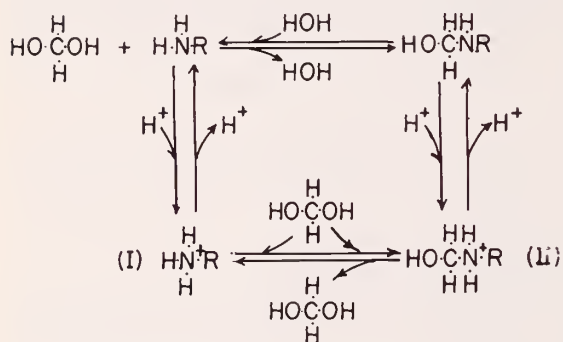
Although the components of this sequence are the simplest of "one-carbon" compounds, the enzymology of the individual reactions is not well defined. The rates of the three processes may also differ in various cell types.

Methanol itself can be oxidized by a NAD⁺-dependent "alcohol dehydrogenase", or by a peroxidative mechanism.



By either reaction it is reasonable that ethanol can function as a competitive substrate and thereby interfere with the initial binding of methanol with the active site of its oxidative enzyme(s).^{20,22,26,27}

Formaldehyde is a highly reactive compound and its distribution in tissues intracellularly is facilitated by its ability to exist both as $\text{HC} = \text{O}$ and as the hydrate, $\text{HO}-\underset{\text{H}}{\underset{|}{\text{C}}}-\text{OH}$ the latter being the predominant species in aqueous media. A prominent nonenzymatic reaction of formaldehyde in biochemical systems is its reversible association with both unprotonated and protonated amino groups, e.g., the ϵ -amino group of lysine:



The acid dissociation constant of II is of the order of 100 to 1000 times greater than for I. In any system containing $-\text{N}^+\text{H}_3$ groups, therefore, there will be a significant increase in the H^+ when formaldehyde is introduced. It is not unreasonable that such an increase in actual acidity could have profound effects on biological systems, especially if these reactions were localized.

Formaldehyde is susceptible to oxidation to formic acid in mammalian cells by a wide variety of enzymes of broad specificities. Indeed, seven or eight enzymes have been shown to be capable of causing dehydrogenation of formaldehyde. In liver tissue, two "formaldehyde dehydrogenases" of somewhat more restricted substrate specificity have been identified, both of which require NAD⁺ (DPN) as the coenzyme.²⁸ The cytoplasmic enzyme requires reduced glutathione as a cofactor, whereas the intra-mitochondrial dehydrogenase does not.[‡] Current studies on the liver enzymes indicate also that there may be a compartmentalization of the mitochondrial dehydrogenase(s) between the inner matrix and the intermembranous space.

It is of interest that the ATP/O ratio observed during formaldehyde oxidation in intact liver mitochondria is two rather than three as would normally be expected from NAD-linked dehydrogenations.²⁹ This lower level of oxidative-phosphorylation efficiency may be attributed in part to the demonstrated ability of formaldehyde to interfere with energy-transduction processes.^{30,31}

Formic acid (with a pK' of 3.75) is one of the strongest acids produced metabolically in mammalian systems. As the free acid it could obviously be injurious if its protons were not neutralized by some acceptor. On the other hand, "formate" (e.g., the Na⁺ or K⁺ salt) is a very weak base and is innocuous. (Formaldehyde, rather than methanol or formate was suggested as "the" toxic agent in methanol intoxication at least as early as 1902).³² The enzymology of oxidation of formate to carbon dioxide is as yet poorly defined in mammalian systems. One pathway would involve the ATP-activated conversion of the formate to a tetrahydrofolate (FH₄) derivative such as N¹⁰-formyl FH₄ and the subsequent oxidation of this "one-carbon compound," via NADP, to CO₂.

With regard to the general metabolism of formaldehyde and formate in man, it should be remembered that both compounds can readily enter the "one-carbon pool" as FH₄^b derivatives

[†] nicotinamide adenine dinucleotide

[‡]WRF, unpublished observations.

^btetrahydrofolate.

(N⁵,N¹⁰-methylene-FH₄, N⁵,N¹⁰-methenyl-FH₄, N⁵-formyl-FH₄, and N¹⁰-formyl-FH₄) and be converted to many other essential metabolites. Following its oxidation, the methanol carbon can likewise be expected to be found in the form of the aforementioned derivatives.

The following lines of evidence favor the conclusion that formaldehyde is the probable toxic agent in methanol poisoning. First, the characteristic latent period before the onset of clinical manifestations (such as acidosis and visual disturbances) approximates the time required for metabolic conversion of the methanol to significant levels of an intermediate such as formaldehyde. Second, the effectiveness of ethanol in counteracting methanol poisoning suggests that the conversion of the alcohol to the aldehyde is obligatory in the development of the toxicity. Thirdly, *in vitro* experiments with retinal preparations indicate that HCHO is far more deleterious than CH₃OH or HCOOH.

The demonstrated ability of HCHO to interfere with the transduction of oxidative energy in mitochondria^{29,30,31} provides an attractive working hypothesis for further studies on the biochemistry of visual impairment in methanol toxicity. It is also inviting to speculate that formaldehyde may play a role in the development of the extreme metabolic acidosis observed in the methanol-intoxicated patient. It is indeed surprising that this dramatic phenomenon has received so little attention by the physiologist in the past fifty years.

Treatment

The three major modalities of treatment of patients with methanol intoxication are: (1) alkalization to neutralize the metabolic acidosis, (2) administration of ethanol to diminish metabolic degradation of the methanol to toxic products, (3) dialysis to enhance the removal of both methanol and its toxic products by physical rather than biochemical pathways.

Alkalization — The profound metabolic acidosis exhibited by patients with methanol intoxication is one of its most striking features. It is very unlikely, however, that the systemic acidosis *per se* is what causes the damage since patients with other disorders can have as marked

or even more marked acidosis without showing the visual disturbances.

Respiratory adjustments are generally inadequate to provide full respiratory compensation. All authors agree that alkali therapy is required and should be given, but the total amounts of NaCHO₃ administered are determined by the response.^{3,21,33} For an initial [HCO₃⁻] or CO₂ content of about 5 mEq/L, the administration of 88 mEq of NaHCO₃ over two hours would be appropriate. Additional amounts would be appropriate subject to repeated determinations of CO₂ content or of [HCO₃⁻] concentrations of less than 8 to 10 mEq/L.

There is a large concentration of undetermined anions in these patients and there may be substantial increases of plasma lactate concentration. Under no circumstances is sodium lactate to be given since it is of no immediate value in the correction of the acidosis.

As to total amounts, several hundred grams of NaHCO₃ frequently have been required. Several moles of methanol may be ingested. Since most of it is disposed of by metabolic rather than physical pathways, unless other measures such as administration of ethanol or hemodialysis are taken, and since two moles of hydrogen ions are produced for each mole of methanol metabolized, the administration of such large amounts of NaHCO₃ should not be a matter for surprise. Further, one must take into account the continued production of hydrogen ions in severe acidosis.

Dialysis — Although it is established that formaldehyde, the degradation product of methanol, is responsible for the toxic manifestations seen after the ingestion of methanol, it obviously makes sense to remove the precursor, methanol, as rapidly as possible from the body. An increase of methanol excretion probably can be achieved by increasing urine flow although this is not an efficient procedure because of the relative volumes of possible urine excretion (5 to 8 liters per day) and of total body water (30 to 45 liters). Thus, dialysis must be used. Two avenues are available: peritoneal dialysis and hemodialysis. The evidence is clear that hemodialysis

which is more effective than peritoneal dialysis¹⁶ is both rapid and safe. Therefore, it is imperative to use this method if it is available.

Administration of Ethanol — As discussed above, it is now generally recognized that ethanol interferes with methanol by a competitive mechanism. Ethanol administration as a 5 percent solution in 0.9 percent NaCl to a total dose of 25 to 50 grams of ethanol must be initiated as soon as the diagnosis of methanol intoxication is entertained. This corresponds to a range of total ethanol from about 0.5 to 1.0 mole. This should be considered a mandatory step in the treatment of methanol intoxication.

Contact with Methanol — Methanol intoxication might be considered a remote accidental occurrence that need not concern us but the following examples may serve to underscore the importance of methanol in industrial products and its closeness to all of us. The first is a recent news item³⁶ which reads in part: "Mixing crude oil with *methanol* from natural gas deposits normally found with oil could be "the most economical and ecologically sound method of oil transport in the Arctic." In brief, heated oil transported through an underground pipeline may melt the Alaskan permafrost. Oil mixed with methanol can be moved at a much lower temperature. The news item concluded by pointing out that methanol itself has a high octane rating (106). Up to 15 percent can be added to gasoline to give greater fuel economy, lower exhaust temperatures and emissions and improved engine performance. It appears likely that methanol production and the potential for exposure are going to increase.

The second example concerns products available in practically every filling station in the New Jersey area — windshield de-icer in a spray can and de-icer for prevention of icing of carburetor and fuel lines. Many of these de-icer materials contain substantial amounts of methanol. Although there is a warning about use in confined spaces, icing may occur inside a car as the ice is melted on the outside with a de-icer product. The temptation to use the de-icer *inside* with the heater going full blast, is unlikely to be overcome by a reading of fine print on the label

of the can. Another source of methanol is the gelled fuel for use in camping stoves.

Summary

Methanol is an important health hazard. It can be absorbed by ingestion and inhalation, and also through the skin. With a history of potential or actual exposure it becomes imperative to treat the patient immediately. The specific measures to be used are: correction of the metabolic acidosis by administration of NaHCO_3 , administration of ethyl alcohol to reduce competitively the metabolism of methanol and removal of the methanol by hemodialysis and by normal excretory routes. With these measures prevention of blindness and complete recovery are possible.

Addendum: Attention is drawn to the recent studies by Makar and Tephly, and their associates, (*Biochem Med* 13:31 319-333; 334-342, 1975) in which they report on the inhibition of methanol oxidation by 4-methylpyrazole in monkeys and suggest that this approach may have applications to man.

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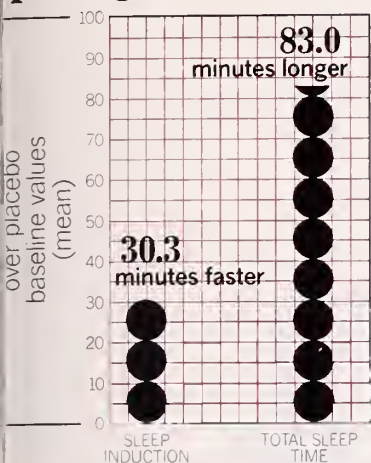
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Before prescribing Dalmane (flurazepam HCl), please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and

falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, e.g., excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

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Some gastrointestinal diseases must be handled with specific dietary regulations and the scientific data available firmly support this approach. Typical of these disorders are celiac disease in which a gluten restriction alone leads to clinical recovery and histological improvement of the small bowel mucosa and hepatic encephalopathy in which protein intake must be controlled. Many other gastrointestinal conditions, perhaps the most frequently seen in the daily practice, are treated with dietary advices that are based more on personal feelings than on proper and adequately proved scientific evidence.

Diets in Gastrointestinal Diseases: Fact or Fancy?

Geobel A. Marin, M.D./Trenton

Long-term controlled clinical trials to determine the true value of dietary restrictions in various gastrointestinal disorders are needed. Specific dietary limitations play crucial roles in the management of diseases such as gluten-sensitive enteropathy, intestinal lactase deficiency, hepatic insufficiency, and some other important though rare metabolic abnormalities. The most common gastrointestinal problems are, however, handled with rather strict dietary advice for which no scientific reason can be found.

The following considerations are aimed at discussing the available data concerning diets and three of the most frequent gastrointestinal problems. The outlined controversy is neither original nor new. Focusing in on this topic appears to be justified in view of the resistance found when the traditional viewpoints are challenged.

Peptic Ulcer Disease

The history of peptic ulcer disease is probably as old as the diets devised to treat it. Little change has occurred since Dr. Bertram W. Sippy advocated the hourly feedings of milk or milk and cream on the hour and the hourly administration of antacids on the half hour more than 50 years ago. Physicians and patients have resisted any change and patients with real or imaginary ulcers continue to drink milk regularly.

Honesty dictates that we act according to what scientific evidence shows. There is now little

doubt that diet bears no connection to the cure or to the recurrence of ulcers.^{1,2} The available data fail to prove that a given diet is more beneficial to an ulcer patient than any other diet. Although the traditional concept is still advocated by well-known gastroenterologists³ the rationale is lacking. A lucid final statement is made by Isenberg⁴ in his comments about diet and peptic ulcer: "There is no evidence that spices in moderate amounts are ulcerogenic or alter the course of ulcer healing or frequency of recurrence. Also, the texture of the diet, soft versus rough, seems to be unimportant in ulcer pathogenesis or therapy." The only logical conclusion derived from analyzing the existing evidence is that physicians adhere to strict diets either because their patients cannot be weaned off bland diets that have been faithfully followed for years or that physicians and patients alike deeply believe in the magic powers of white, bland, clean foods. It thus appears that with the exception of known gastric stimulants (caffeine and alcohol), there is no valid reason to prescribe diets in the management of patients with ulcer disease.

Chronic Gallbladder Disease (Silent Cholelithiasis)

Low-fat diets are frequently advised for the patient with silent gallstones in whom surgery is not advisable. Similar dietary orders are given to

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patients in whom surgery is postponed. The reasons behind such recommendations defy logical explanations. Gallbladder contractions and emptying are stimulated by the gastrointestinal hormone cholecystokinin, mostly in response to a protein meal.⁵ Thus, if any stimulant to gallbladder contraction is to be avoided, a low protein diet would be the choice. However, dietary changes bear no relationship to the incidence of recurrent attacks of cholelithiasis. Furthermore, prolonged dietary restrictions in cholesterol intake change the composition of human bile⁶ and increase the molar percentage of bile cholesterol. A low cholesterol diet might predispose to cholesterol gallstone disease.⁷ In summary, low fat diets which may also be low cholesterol diets play no role in the management of the patient with gallstones and might increase the formation of cholesterol gallstones. The commonly heard concept that fats are associated with gallbladder attacks has not been proved to be true when blind trials are conducted.

Diverticulosis Coli

For generations, patients with diverticular disease of the colon were advised to remain on low residue diets. Persons with this disorder, whether symptomatic or not, have been instructed to carefully avoid seeds, pulps, corn-germ meals, and all foods that could potentially get impacted in one of the little diverticuli. That this advice seems to be erroneous is the conclusion obtained from epidemiologic and laboratory studies. Diverticular disease of the colon has become a major medical problem only in the last 50 years and is almost unknown in communities where individuals eat a high-residue diet.⁸ A high-residue diet relieves symptoms in the majority of patients⁹ and the disease can be reproduced experimentally in animals fed a low-residue diet.¹⁰ Although limited and yet incomplete, clinical trials demonstrate that consumption of 20 grams of bran each day shortens the intestinal transit time in patients with diverticular disease and increases stool weight in healthy persons.¹¹ Thus, efforts should be made to increase the stool weight in patients with diverticular disease of the colon to prevent recurrences and in healthy persons to avoid the formation of diverticuli by increasing the dietary

sources of fiber. The low-residue diet in the management of diverticulosis coli is defunct.

It has been said that tradition dies hard. Nowhere does this axiom seem to be more true than in regard to diets and some of the most common gastrointestinal problems. Although hard to accept, many of the most believed concepts prove to be false when critically analyzed:

"Even in the case of views that are more generally agreed upon, it is of value to re-examine the evidence, for it is an old story that opinions supported by little more than the weight of early authority often have remained embedded for years in the corpus of science through the failure to inquire into the validity of the observation upon which the opinions rest."¹²

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2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
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“Approximately 95% of the [U.S.] children of ages 1-5 years had iron intakes below the standard”

U.S. Public Health Service (1974)

Where did that surprising statistic originate?

From the first survey designed to assess the nutritional status of the entire U.S. population. The conclusion above was the most striking result reported in the preliminary findings released in January 1974.

Were they really dealing with a true sample of the entire U.S. population?

Those conclusions were based on a sample of 10,126 people—a probability sample established by the U.S. Bureau of Census to reflect the country's total population, regardless of race or income.

Among those 95% with substandard iron intake, how low was their intake actually?

For whites and blacks, for both sexes, for both income levels, the mean intake of iron (as a percent of the standard) for the 1-5 year age group ranged from 60 to 69%. Typically, then, 95 children out of 100 have iron intakes that are only 2/3 of the standard.

Whose iron intake standard were they using?

The standard set by the Food and Nutrition Board of the National Academy of Sciences for this group.

Implication of all this?

That iron deficiency among preschoolers is anything but rare and signs like mental apathy, lethargy, irritability, behavior problems, may be telegraphing iron deficiency.

Suggesting iron supplementation?

Not necessarily. In many instances this situation can be corrected by proper diet and, obviously, this is the preferred route. When dietary improvement is not attainable, consider a supplement.

But consistent use of an iron supplement is difficult to achieve.

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Is this cited study generally available?

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*B. Blackwell: The Drug Defaulter. *Clinical Pharmacology and Therapeutics* 13:841 (1972).

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Hamartomas or angiomyolipomas are benign tumors which, with difficulty, frequently can be radiographically differentiated from renal carcinomas. The fatty tissue element of the tumor sometimes dominates and a radiolucent abdominal mass on the plain film of the abdomen can suggest the correct diagnosis. Renal angiography frequently presents a characteristic vascular pattern which distinguishes the lesion from malignant tumors. Two clinical case reports are presented with a discussion of the radiographic findings.

Radiologic Distinguishing Features of Angiomyolipoma of the Kidney

**M. Rothberg, M.D.,
W. E. Matthey, M.D., and
J. Bastidas, M.D./Livingston***

The diagnosis of renal mass lesions, especially the differential diagnosis between benign cystic lesions or renal hypernephromas, has been markedly enhanced by the advent of abdominal and selective renal angiography.⁵ However, angiographic studies of renal masses have revealed benign hypervascular tumors which are extremely difficult to differentiate from hypernephromas.¹ The most common of these tumors is the congenital angiomyolipoma or hamartoma. There are certain criteria which, when present, enable the radiologist to distinguish the benign hamartoma from the malignant renal carcinoma. Correct preoperative diagnosis of the benign lesion allows the surgeon the opportunity to resect only the portion of the kidney attached to the mass instead of a total nephrectomy, therefore saving functioning renal tissue.

Recently we had two proven cases of this entity which illustrate the difficulties involved.

Case 1

A 50-year-old female was admitted to Saint Barnabas Medical Center with a one-week history of low back pain, a one-month history of anorexia, and a weight loss of ten pounds. There were no symptoms referable to the genitourinary tract.

Physical examination revealed the abdomen to be distended, but not rigid. Direct and rebound tenderness was noted in the left lower quadrant of the abdomen. On vaginal examination a pelvic mass was noted on the left.

The patient's temperature was 101 degrees, with a white blood count of 10,700 and a shift to the left. The E.S.R. was 102. The urine was negative for red or white blood cells.



Figure 1

A barium enema (figure 1) was performed which demonstrated acute diverticulitis of the sigmoid colon which was compatible with the clinical diagnosis. At that time, an asymptomatic mass in the right renal area with extrinsic pressure upon the hepatic flexure of the colon was noted. The mass appeared lucent when compared to the normal soft tissue shadows of the psoas muscles and intestines which are readily visible.

An excretory urogram (figure 2) demonstrated the mass from the lower pole of the right kidney. Selective renal arteriography of one of the two right renal arteries (figures 3

*From the Department of Radiology of St. Barnabas Medical Center, Livingston, where Dr. Rothberg is Associate Attending Radiologist, Dr. Matthey is Director of the Department, and Dr. Bastidas is Attending Radiologist.



Figure 2



Figure 3

and 4) revealed a normal main renal artery with marked neovascularity, arterial tortuosity, and pseudoaneurysm formation with pooling of contrast in sac-like formations. There was no evidence of arteriovenous fistulas or early venous filling. The renal vein was intact.

Of extreme importance was the lucent appearance of the mass on the barium enema. Common renal masses such as renal cysts, which are fluid filled, and renal neoplasms, which are solid, present on radiographs as soft tissue density masses and not lucent masses. This finding was not as apparent on the excretory urogram.

Angiographically, the neovascularity visualized is similar to that found in renal carcinomas making the differential



Figure 4

diagnosis difficult. The pseudoaneurysms noted are one of the main characteristics of renal angiomyolipomas, although they are not found in every case. The lack of arteriovenous shunting or early venous filling is another important differential point for the diagnosis of angiomyolipoma demonstrated in this case.

Case 2

A 44-year-old female was admitted to Saint Barnabas Medical Center with severe right-sided abdominal pain plus vomiting of four hours duration. The remainder of the history was non-contributory.

Physical examination revealed the presence of a palpable right upper quadrant mass with a distended and tender, but non-rigid, abdomen.

Laboratory findings were non-contributory. A urinalysis revealed no evidence of white or red blood cells.

A plain film of the abdomen revealed a mass lesion in the right mid-abdomen. The right renal outline and right psoas shadows were not visualized.

An excretory urogram revealed a large right renal mass lesion displacing the axis of the right kidney laterally and superiorly, with normal kidney function.

An abdominal aortogram and selective right renal angiogram (figure 5) revealed evidence of a large mass lesion originating from the medial aspect of the lower pole of the right kidney with neovascularity, pooling of contrast medium in the sac-like collections of pseudoaneurysms, absence of arteriovenous shunting, and a normal venous phase.



Figure 5

The mass was not lucent on the plain films as in Case 1. However, the presence of pseudoaneurysms and lack of arteriovenous shunting are characteristic of renal hamartomas. The sex and age of the patient are also typical for renal hamartomas.

Discussion

Renal hamartomas are mesenchymal tumors composed of blood vessel, smooth muscle, and adipose tissue elements native to the organ, but in an abnormal mixture. There are also microaneurysmally degenerated tumor vessels. The tumors are usually peripherally located, grow very slowly and rarely penetrate through their capsule. There are many pathological types depending on the type of tissue predominating.

Hamartomas are commonly associated with tuberous sclerosis, having been noted in 40 to 80 percent of these patients; although most of these are extremely small and usually bilateral, some having been found as incidental findings at autopsy.

Hamartomas not associated with systemic tuberous sclerosis are larger and unifocal. They are predominately found in women in the fifth to seventh decades of life. The tumors are usually asymptomatic and frequently are accidentally discovered in the work-up of non-associated diseases.⁴ This was true in Case 1 where the mass was noted in the work-up for acute diverticulitis. Others may complain of fever, flank pain,

hematuria, or an abdominal mass. There is a tendency for spontaneous infarction or hemorrhage into the tumor with a clinical picture of pain, hemorrhage, and shock.

Excretory urograms aid in localizing the tumors. If fatty tissue dominates the other pathological elements, the mass may appear lucent as did our first case. Fatty tumor tissue is better demarcated than degenerated fat in malignant tumors.

Angiographically, Viamonte⁶ has called the appearance of hypervascularity and pseudoaneurysm formation of the intrarenal arteries similar to that of a "cluster of grapes." Clark and Palubinskas² reviewed twenty-six renal hamartomas without tuberous sclerosis and found angiographically that four percent were avascular renal masses, 68 percent had neovascularity indistinguishable from malignant renal tumors, 16 percent had the characteristic multisacculated pseudoaneurysms, whorled onion-skin venous phase, and well-defined lucent areas during the nephrogram phase, and 16 percent had delicate discrete neovascularity supplied by normal interlobar arteries.

The differential diagnosis consists of renal hypernephroma, angioma, angiosarcoma, and arterial-venous malformations in addition to other rarer tumors such as leiomyomas and lipomas.³

In a majority of the cases, the benign nature of the tumor may be suspected by the lack of arteriovenous shunting from angiography. Classically, the benign diagnosis of angiomyolipoma of the kidney is confirmed when a middle-aged asymptomatic or symptomatic woman with a lucent mass reveals characteristic pseudoaneurysms and lack of arteriovenous shunting on angiography. A correct preoperative diagnosis can prevent a total nephrectomy and spare surgical removal of normal functioning renal tissue.

Addendum

Since this article was written, we have had a case of a 34-year-old male presenting with a large retroperitoneal mass with multiple areas of lucency within the mass on abdominal radiographs. A retrograde pyelogram and excretory urogram revealed the mass originating from the left kidney.

Selective renal angiography demonstrated pseudoaneurysms, lack of arteriovenous shunting, and abnormal vascularity typical of a renal angiomyolipoma.

Although the mass was quite large (the pathological specimen weighing over 2,500 grams) only 25 percent of the kidney was resected with the mass, leaving the patient 75 percent of normal functioning renal tissue.

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Old Short Hills Road, Livingston

American College of Radiology Commission on Cancer Interim Statement on Breast Cancer Diagnosis

Mammography has proved to be the most effective diagnostic tool so far developed for the detection of breast cancer at an early stage before it spreads to regional lymph nodes. This early detection increases the probability of cure. Mammography at appropriate intervals in asymptomatic women over age 35 promises to reduce significantly the number of deaths from breast cancer.

Since there is now no definitive scientific evidence with regard to (1) optimal age for the initial mammogram, (2) frequency of examination, or (3) data on possible long-term radiation risk, this statement is being issued as a summary of current informed opinion.

Care of Women with Symptoms — In women who have symptoms or physical findings suggestive of possible breast cancer, medical decisions must be individualized to fit the patient's needs. Under these circumstances, mammography is an integral part of the evaluation of the patient.

Screening of Asymptomatic Women — Recognizing that definitive data are not yet available to define a protocol for the screening for breast cancer in asymptomatic women, the ACR recommends the following:

1. All women should have annual physical examinations of the breasts and be taught breast self-examination.
2. For asymptomatic women, the first, or baseline, mammographic examination should be performed between the ages of 35 and 40.
3. Subsequent mammographic examinations should be performed at one to three year intervals unless more frequent examination is medically warranted.
4. After age 50, annual or other regular interval examinations, including mammography, should be performed.
5. Although the carcinogenic effects of radiation at current levels of exposure are probably immeasurably small, continuing attempts to reduce exposure should be made. However, image quality must be preserved for accurate diagnosis to insure the best risk/benefit (cure) ratio.
6. Each radiologist should assure the periodic monitoring of his equipment and procedures to determine that the patient's exposure is being maintained at the lowest feasible level.

CASE REPORTS

A patient with an incomplete testicular feminizing syndrome is presented. Treatment consisted of gonadectomy and estrogen replacement followed by vaginal reconstruction. The patient had many psychological difficulties but showed a significant improvement following vaginal reconstruction. She actively participated in sexual relations, and was satisfied with her new female role. Vaginal reconstruction is recommended for patients with this syndrome.

Vaginal Reconstruction in Testicular Feminizing Syndrome

**Sheldon Rothfleisch, M.D.,
Herbert A. Dietzel, M.D.,
Vatsala Rao, M.D./New Brunswick**

In recent years surgery has attained a recognized position in the treatment of intersex conditions. The differential diagnosis of ambiguous genitalia under this general heading includes the male intersex feminizing-testis type.

Diagnosis

These patients usually give a family history of intersex problems. They present with primary amenorrhea and a feminine appearance and have been shown to have either intra-abdominal, inguinal, or labial testes. Usually the breasts are developed, but axillary and pubic hair are either scant or absent. The external genitalia are those of a normal female, although the labia minora are usually underdeveloped. The vagina consists merely of a blind pouch. The clitoris often is not enlarged. The uterus is absent and occasionally rudimentary oviducts can be found.

The diagnosis often can be made on physical examination supplemented by X and Y chromatin determinations and endocrine studies. Urinary 17 ketosteroids and their fractionation are generally within normal limits for female or male. Plasma testosterone values are within normal limits. After castration the value of 17 ketosteroid excretion and plasma testosterone decreases. The urinary estrogen values are within normal range for male and female and are decreased after gonadectomy. In exceptional cases, karyotyping or even laparotomy is necessary.

In male intersex, feminizing type, the buccal smear shows no Barr body and the stain for Y-chromatin is positive. There are usually no associated major somatic anomalies.

Although this syndrome is uncommon, a beneficial response to gonadectomy can usually be expected. From the psychological aspect, however, these patients may benefit additionally from reconstructive plastic surgical intervention. Procedures to be considered are vaginal reconstruction, breast augmentation, if necessary, and rhinoplasty to attain a more feminine facial appearance.

Case Report

A 32-year-old female, previously untreated, presented with amenorrhea, enlarged clitoris, hirsutism and a deep voice. The patient was an alcoholic and had been under psychiatric care for many years. Physical examination revealed a well developed, masculine-appearing woman with hirsutism. Genital examination disclosed a male escutcheon and an enlarged clitoris of approximately three centimeters. The labia majora and minora were well formed. The vagina consisted of a blind pouch approximately two centimeters in depth. No pelvic organs were noted. Gonads were palpated in the lower inguinal canal bilaterally, measuring approximately 1.5×2.5 centimeters. The breasts were small.

An intravenous pyelogram and chest x-ray were within normal limits. Laboratory data revealed a normal hemogram and SMA 12. Additional pertinent laboratory data were as follows:

Treatment — Potential malignant transformation of the gonads constitutes the indication for gonadectomy.

Dr. Rothfleisch is Clinical Assistant Professor, Plastic Surgery, Rutgers Medical School, Piscataway; Dr. Dietzel is Director of Obstetrics and Gynecology, St. Peter's Hospital, New Brunswick, where Dr. Rao is on the Attending Staff in that department.



Figure 1 — Pre-operative.

Generally, it is believed that this does not occur prior to age twenty. Gonadectomy can be coupled with vaginal lengthening at the same surgery, but in our patient, gonadectomy was performed as a separate procedure from vaginal lengthening because of her age and to allow time for adequate psychological preparation for this phase of her treatment. Histological sectioning of the gonads revealed testicular tissue. Following surgery, the serum testosterone level dropped to 66 ngms/24 hrs. and the 17 ketosteroid was 7.9 ngm/24 hrs. Maintenance estrogen administration was instituted following surgery. Six months later, the patient underwent a second operative procedure.

Vaginal Reconstruction — Under general anesthesia with the patient in the lithotomy position, a transverse incision was made at the blind end of the two centimeter vaginal pouch. By blunt finger and instrument dissection, the fatty areolar tissue of the retrovesical space was dissected to a depth of ten centimeters. Packing was inserted into the newly created vault to control small bleeding points.

An obturator was fashioned from styrofoam (figure 2) approximating the depth of the newly created vault. Utilizing a



Figure 2 — Obturators.



Figure 3 — Obturator in place with graft in-situ.

Reese Dermatome* with setting at 0.018 inch thickness, a thick split skin graft was taken from the left buttock. With the graft reversed, i.e. raw side out, a tube was fashioned from the graft around the styrofoam obturator, using 5-0 chromic catgut. The obturator was first covered with a single layer of xeroform gauze and the graft was then fitted to the stint. (See figures 3 and 4) The stint and graft were then positioned in the previously created pouch with a T-binder. Interrupted sutures of 5-0 chromic were placed in the introitus to fix the graft anteriorly. The skin graft was not perforated prior to insertion.

The patient was kept at bedrest for three days and then allowed to ambulate with the obturator held in place with the T-binder. On the seventh postoperative day, the stint was removed and the graft appeared completely viable. On the ninth postoperative day the obturator was removed and replaced, and the patient was discharged from the hospital. The patient was instructed to douche at least three times per week. In addition, she was instructed to wear the obturator

Test	Pre-op	Post-op	Normal Values	
			Male	Female
Serum Testosterone	411 ngms	66 ngms	300-800 ngm.	25-100 ngm.
Urinary 17 Ketosteroid	12.3 mg./24 hr.	7.9 mg./24 hr.	9-12 mg./24 hr.	6-15 mg./24 hr.
Urinary 17 Hydroxy Ketosteroid	19.5 mg./24 hr.	7 mg./24 hr.	9-25 mg./24 hr.	6-18 mg./24 hr.
Urinary Estrogen Content	81 mcgm./24 hr.		4-14 mcgm./24 hr.	4-110 mcgm./24 hr.
FSH	62 mouse units			6-50 m.u.
Pregnanetriol	3.4 mg./24 hr.		0.4-1.5 mg./24 hr.	0.5-6.0 mg./24 hr.
Chromosomal Karyotype	46 XY			

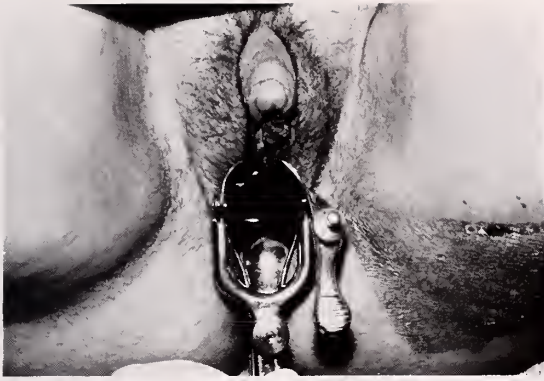


Figure 4 — Post-operative final result showing depth of vaginal vault.

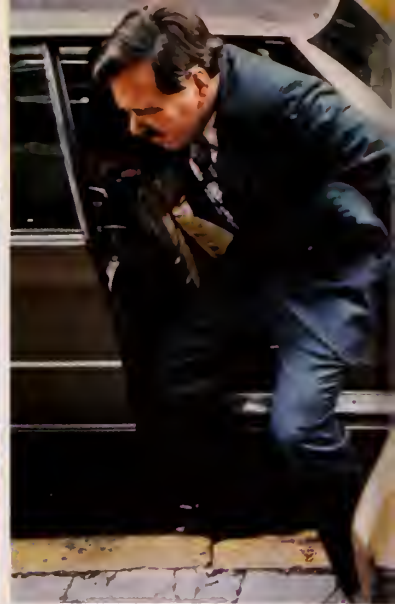
for six months, except during intercourse. Sexual activity was encouraged as being an effective means toward maintaining patency of a newly constructed vault.

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Allergic or Idiosyncratic: In previously unexposed patients, these are usually seen after 1-4 doses and include rash, erythema multiforme, pruritus, eosinophilia, fixed drug eruption with cross reaction to meprobamate. Asthmatic episodes, fever, weakness, dizziness, angioneurotic edema, smarting eyes, hypotension and anaphylactoid shock may be manifestations of severe reactions. In such cases, stop carisoprodol and initiate appropriate treatment (e.g., epinephrine, antihistamines, corticosteroids).

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Overdosage: Has produced stupor, coma, shock, respiratory depression, and, very rarely, death. The effects of an overdosage of carisoprodol and alcohol or other CNS depressants or psychotropic agents can be additive even when one of the drugs has been taken in the usual recommended dosage. Empty stomach, treat symptomatically; cautiously give respiratory assistance, CNS stimulants, pressor agents as needed. Carisoprodol is metabolized in the liver and excreted by the kidney. Diuresis and dialysis have been used successfully with related drug meprobamate. Carefully monitor urinary output; avoid overhydration; observe for possible relapse due to incomplete gastric emptying and delayed absorption.

Before prescribing, consult package circular or latest PDR information.

A newborn infant presented with vomiting at birth and was found to have gastric outlet obstruction from an antral web. Very few cases of antral web occur in the newborn period and the histology of the obstructing lesion is different in the child and in the adult. The incomplete presence of the entire mucosal-serosal gastric wall in adult cases would indicate that these are probably acquired lesions while the ones in the neonatal period are true congenital anomalies. In the newborn period the diagnosis may be confused with that of pyloric stenosis. The lesion is corrected by gastrotomy and excision of the gastric web.

Newborn Gastric Outlet Obstruction Caused by an Antral Web

**D.N. Patnaik, M.D., S. Sun, M.D.,
and D.B. Groff, M.D./Newark***

There have been periodic reports of antral web obstruction of the gastric outlet since Berman and Ballinger's first report in 1942,¹⁻⁸ but only five cases have been reported in the neonatal period and early infancy,^{2,5,8} with the majority in later childhood or in the sixth or seventh decade of life. This age distribution and other reasons to be discussed indicate that there are two forms of antral web obstruction, congenital and acquired. The symptoms, diagnostic findings, and treatment of the congenital variety of antral web are illustrated by the following patient.

Case Report

A three-day-old female child, product of a normal pregnancy and normal spontaneous delivery, was transferred to the Children's Hospital of Newark (United Hospitals Medical Center) on October 14, 1974 with a history of repeated non-bilious vomiting since 12 hours after birth. A gastrointestinal series was interpreted as showing "pyloric stenosis."

Physical Examination — The patient weighed 7 lbs. 2 oz., appeared mildly dehydrated and had an epigastric fullness but no peristaltic waves across the abdominal wall and no palpable abdominal mass. The rest of the physical examination was within normal limits.

X-Ray Findings — The plain views of the abdomen showed a mildly dilated stomach with normal-appearing gas pattern throughout the rest of the intestinal tract. An upper gastrointestinal x-ray series showed a persistent filling defect across the antrum of the stomach with delayed passage of barium (see figure 1); this was interpreted as an antral web obstruction to the stomach.



Figure 1 — Upper gastrointestinal series showing the antral web (arrow) which allows only a small trickle of barium to pass into the duodenum. This might be confused with pyloric stenosis.

Course In Hospital — The patient was operated upon October 16, 1974. The stomach, pylorus, and duodenum had a normal external appearance. A three cc. Foley catheter was introduced through a small gastrotomy incision in the stomach and passed through the duodenum into the jejunum. With the balloon inflated, it was impossible to withdraw the balloon through the antral area of the stomach. The small gastrotomy was extended in a longitudinal direction over

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the web; the posterior wall of the web was excised, and the posterior wall of the mucosa was then over-sewn and the gastrotomy closed as a Heineke-Mickulicz gastropasty. A Stamm gastrostomy and appendectomy were performed. The postoperative period was uneventful and the child was discharged on the tenth postoperative day. At three months of age there was normal growth and development.

Discussion

The symptoms of an obstructing antral web in the newborn infant are vomiting and failure to thrive. The diagnosis is easily confirmed by an upper gastrointestinal x-ray series which should be performed on any infant who shows persistent spitting, regurgitating, vomiting, and inability to gain weight.

A comparison of the histology of the excised web from our newborn patient with histology reported from webs excised from older patients is interesting. Histologic examination of the congenital web (figure 2) shows that it consists of a layer of mucosa with a well-defined but somewhat unorganized smooth muscle component. In contrast, adults with antral webs who

characteristically have had symptoms for only a short time showed an absence of mucosa or the presence of mucosa with inflammatory cells and a very small number of muscle fibers with a high proportion of fibrous tissue.⁹ These histologic findings in antral webs in adult patients are more compatible with an acquired lesion.

In the embryo the stomach does not go through a solid stage as does the duodenum and part of the small bowel, so the presence of antral webs cannot be attributed to failure of resolution of the solid state as in duodenal atresia. Further, it is unlikely that the congenitally present web would remain asymptomatic for 50 or 60 years. The evidence suggests that only a small percentage of antral webs are congenital in origin and that most are acquired lesions.

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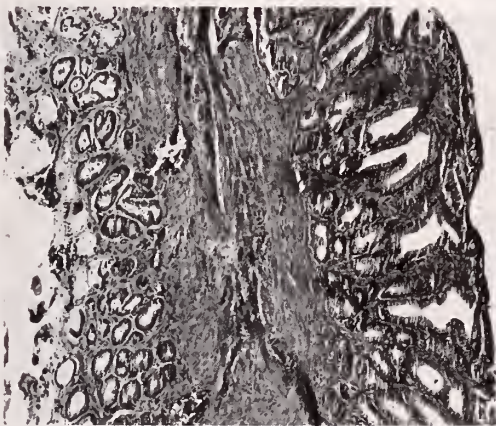


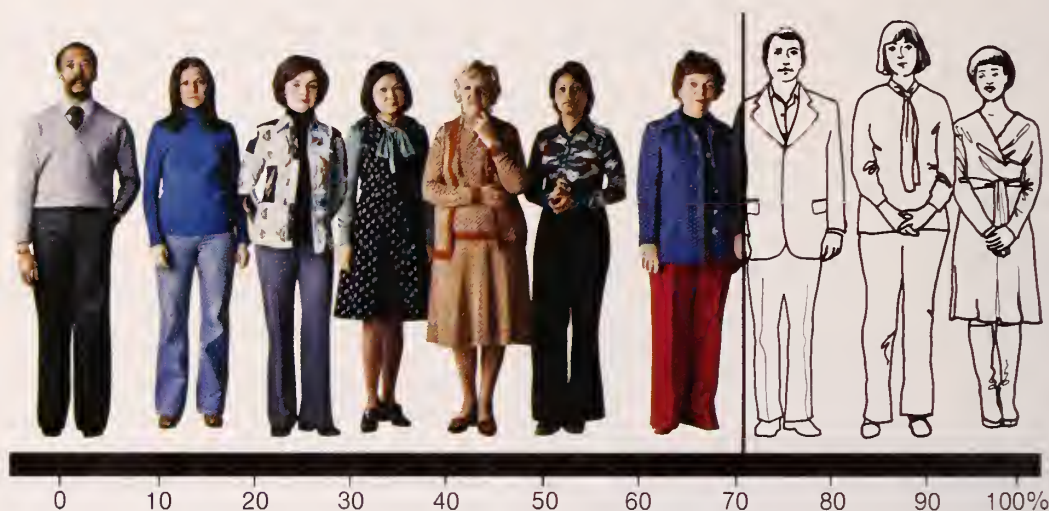
Figure 2 — 135X magnification of an H and E section of a gastric wall web showing the mucosal border with the extensive smooth muscle in the wall of the web. There is a complete absence of fibrous tissue and inflammatory cells.

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In a multicenter, double-blind study of patients with chronic or frequently recurrent urinary tract infection, 10-day therapy with Bactrim outperformed ampicillin 10-day therapy by 27.2% when comparing patients who maintained clear cultures for 8 weeks. When compared at the end of therapy, 90.4% of 83 Bactrim-treated patients had clear cultures in contrast to 81.7% of 82 ampicillin-treated patients. Of even greater significance is the fact that a higher percentage of Bactrim-treated patients maintained clear cultures for 8 weeks. Criterion for "clear culture" was 1000 or fewer organisms/ml urine.

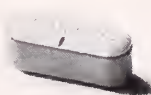
Adverse reactions noted in this study were relatively mild, e.g., nausea, vomiting, rash. However, more serious side effects can occur with the agents studied. Please see product information of each manufacturer for complete listing of adverse reactions.

Note: Bactrim tablets were used in these clinical trials. Bioequivalency studies show one Bactrim DS double strength tablet is equal to two Bactrim tablets.

Bactrim[™] DS

(160 mg trimethoprim and 800 mg sulfamethoxazole)

Double Strength tablets/Just 1 tablet B.I.D.



Bactrim[™]

(80 mg trimethoprim and 400 mg sulfamethoxazole)

2 tablets B.I.D.



For chronic or frequently recurrent cystitis and
pyelonephritis due to susceptible organisms.

Please consult summary of product information on following page.

ROCHE

Significant Prescribing Factors:

- Primarily for chronic or frequently recurrent cystitis and pyelonephritis due to susceptible strains of *E. coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris* and *Proteus morganii*.
- Usual therapy 10 to 14 days.
- Contraindicated during pregnancy or the nursing period.
- Maintain adequate fluid intake; perform frequent CBC's and urinalyses with microscopic examination.
- SxT sensitivity discs available to test sensitivity to Bactrim.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Chronic urinary tract infections evidenced by persistent bacteriuria (symptomatic or asymptomatic), frequently recurrent infections (relapse or reinfection), or infections associated with urinary tract complications, such as obstruction. Primarily for cystitis, pyelonephritis or pyelitis due to susceptible strains of *E. coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris* and *Proteus morganii*.

NOTE: The increasing frequency of resistant organisms limits the usefulness of antibacterials, especially in these urinary tract infections. The recommended quantitative disc susceptibility method (*Federal Register*, 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted. **Data are insufficient to recommend use in infants and children under 12.**

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions,

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(160 mg trimethoprim and 800 mg sulfamethoxazole)
Double Strength tablets

Bactrim
(80 mg trimethoprim and 400 mg sulfamethoxazole)
tablets

epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia, allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, somnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for children under 12. Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) 4 teasp. (20 ml) b.i.d. for 10-14 days.

For patients with renal impairment:

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Below 15	Use not recommended

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Malignant giant cell tumor of soft parts is a rare lesion and it is even more rare to find these lesions in places other than soft tissues. Because of their similarity with entities such as malignant fibrous histiocytomas, giant cell tumors of tendon sheath, fibrosarcomas, and extraskeletal osteosarcomas, the examining pathologist must keep in mind the differentiating criteria between these to arrive at a proper differential diagnosis.

Primary Prostatic Malignant Giant Cell Tumor of Soft Parts

**G. Ramirez, M.D., S. Cohen, M.D.,
and J. T. Kim, M.D./Metuchen ***

Malignant giant cell tumor of soft parts is a rare lesion with a histological picture closely resembling giant cell tumors of bone and malignant fibrous histiocytomas. In some cases, differentiation from extraskeletal osteosarcomas and even fibrosarcomas may be difficult.

Malignant giant cell tumor of soft parts has been reported to occur in the extremities, face, skeletal muscle, trunk, subcutis, superficial and deep fascia and tendon sheaths. In an analysis of 32 such tumors by Guccion and Enzinger¹ from the files of the Armed Forces Institute of Pathology, their location included: knee, leg, thigh, abdominal wall, back (sacral region), face, trapezius muscle and forearm.

To our knowledge, this tumor has not been described in the prostate as a primary site. This report deals with a primary tumor of the prostate, which we believe represents a malignant giant tumor of soft parts and may be the first case of this lesion reported in the prostate.

Case Report

A 68-year-old man was admitted to the hospital January 7, 1972 because of urinary retention and an enlarged prostate gland. He had nocturia, frequency, and hesitancy for several years, and a recent history of two episodes of urinary retention. He had a cystoscopy done two years previously but no biopsy was taken at that time. The rest of the history was non-contributory.

Physical examination revealed a grade three enlarged prostate, bilateral inguinal hernias, atrophic testis and chronic right epididymitis.

Laboratory Findings — Urinalysis showed one plus albumin, 1.022 specific gravity, 10 to 20 red blood cells/hpf; 8 to 14 white blood cells/hpf and some bacteria. Complete blood count, blood chemistry, including calcium, phosphorus, BUN, uric acid, glucose, protein and acid phosphatase, were within normal range.

Routine chest x-ray was normal and intravenous pyelogram showed normal tracts, but a large residual urine.

Operative Findings — The patient underwent a suprapubic prostatectomy two days after admission. The urinary bladder was thick-walled; the prostate gland showed a huge right lobe with a necrotic cavity within the lobe. This cavity was felt to extend into the retroperitoneal space and because of its size, the impression was that, at the time of this operation, the tissue removed "did not at all represent the size of the mass."

Pathology Report — The specimen consisted of several irregular to ovoid masses of rubbery, tan, pinkish tissue that weighed 41 gms. The size of these masses varied from 1.0 x 0.6 cm. to 3.7 x 2.5 cm. The largest of the specimens showed areas of cystic degeneration with hemorrhage and filled with a brownish somewhat soft tissue (Figure 1). Other areas had a honeycomb appearance. There were also areas of yellowish streaks and firm, nodular white tissue.

The microscopic examination demonstrated a malignant lesion which was primarily characterized by elongated and spindle-shaped cells with hyperchromatic nuclei and mitotic activity interspersed with many multinucleated giant cells (Figures 2 and 3). Foci of osteoid changes (Figure 4) and vascular invasion were present.

Other findings were benign prostatic hyperplasia (Figure 5) and acute and chronic prostatitis.

The slides of this lesion were submitted for consultation to the Armed Forces Institute of Pathology and the diagnosis of malignant giant cell tumor of soft parts was confirmed.

The patient's post-operative course was uneventful, except for an episode of bleeding following removal of the suprapubic tube. Ten days after surgery, the patient was transferred to Memorial Hospital, in New York City, where

*From the Center for Laboratory Medicine, Metuchen, and Fair Lawn Memorial Hospital, Fair Lawn.

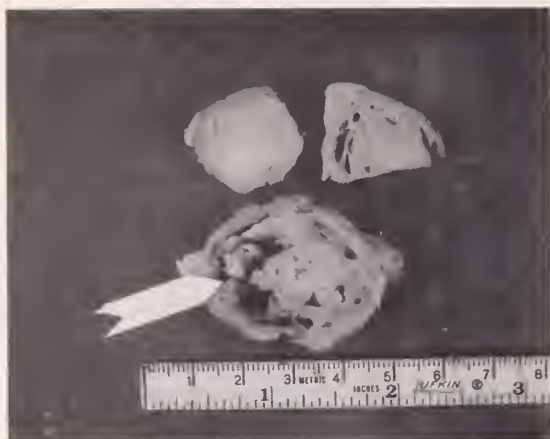


Figure 1 — Gross specimen; arrow points to cystic cavity filled with tumor.

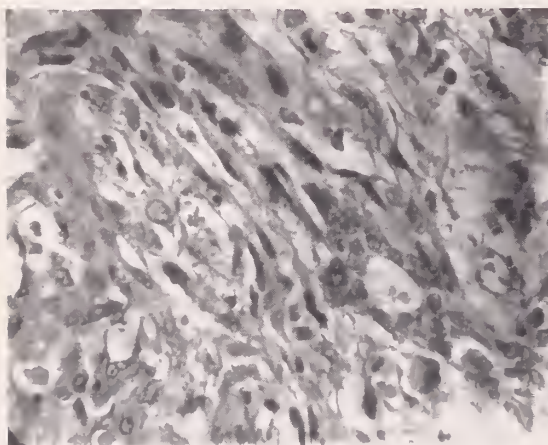


Figure 2 — Area of tumor with malignant spindle cells.

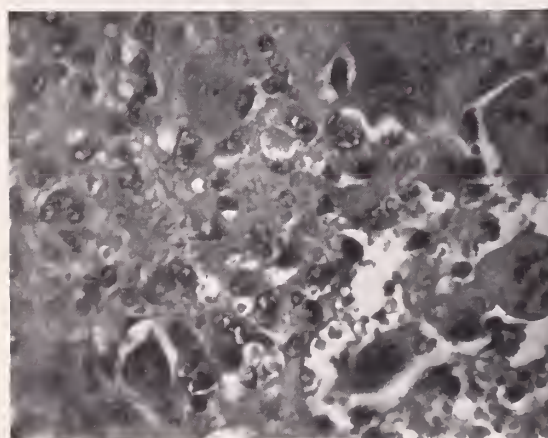


Figure 3 — Area of tumor characterized by multinucleated giant cells.

he underwent "cystoscopy and total exenteration, sigmoid loop urinary diversion and a sigmoid colostomy." The pathology report was "Fully malignant spindle and giant cell



Figure 4 — Focus of osteoid change found on microscopic examination.

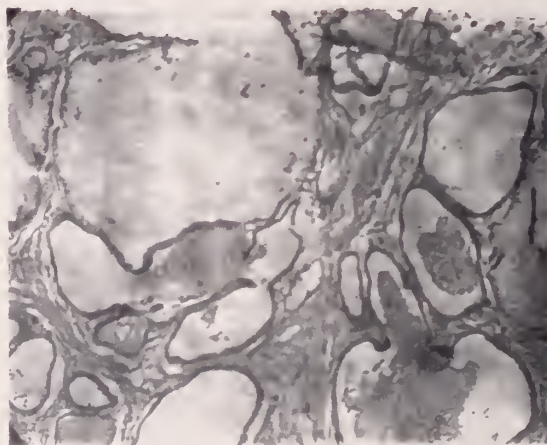


Figure 5 — Area of benign prostatic hyperplasia.

sarcoma of the prostate." There was extension to the seminal vesicles noted. Other findings included "Benign prostatic hyperplasia and chronic prostatitis." He was discharged three weeks after surgery.

Follow-up: The patient was readmitted to Memorial Hospital on May 24, 1973 because of abdominal distention and inability to move his bowels for about two weeks.

At admission he was cachectic and anemic; x-rays of the chest and abdomen showed nodular densities in the right and left lungs, presumably metastatic, and partial intestinal obstruction. The patient deteriorated rapidly despite a trial course of chemotherapy with mithramycin and vincristine. The BUN rose to 97 mg/dl, and serum creatinine to 4.8 mg/dl. Patient expired two weeks after admission, but no autopsy was done.

Comment

The malignant giant cell tumor of soft parts is a rare tumor with a histological picture that has been diagnosed as fibrosarcoma, extraskeletal osteosarcoma, and malignant fibrous histio-

cytoma. This confusion is explained by the finding of areas which resemble these entities in malignant giant cell tumor of soft parts, a distinguishing feature is that these areas are almost always confined to small portions of the tumor.

The lesion most closely related to the malignant giant cell tumor of soft parts is the malignant fibrous histiocytoma (malignant fibrous xanthoma). Careful examination will, however, show that the former contains a greater abundance of multinucleated giant cells and that there are areas of osteoid or bone tissue in about half the cases. There are also histological similarities with giant cell tumor of tendon sheaths, which has also been reported as malignant in a few cases.^{2,3}

No firm conclusion has been established as to the histogenesis of the malignant giant cell tumor of soft parts but the evidence indicates a probable histiocytic origin.¹ In the malignant giant cell tumor of tendon sheaths, the histogenesis points to synovial origin and in osteosarcomas and fibrosarcomas, the origins, of course, are osseous and fibrous tissues.

The histiocytic origin of the malignant giant cell tumors of soft parts has been postulated because of the close resemblance of histiocytes and these neoplastic cells, the phagocytic activity of the tumor cells and multinucleated giant cells, and by the presence of asteroid bodies in the cytoplasm of the multinucleated giant cells. In fact, it is believed that the only neoplasm with asteroid bodies in the multinucleated giant cells is the malignant giant cell tumor of soft parts.¹ In our case, we were unable to demonstrate asteroid bodies.

These tumors frequently contain a spindle cells component, which has been considered to be fibroblasts. In some lesions they have been found at the periphery while in others they are

mixed with the histiocytic mononuclear cells and the multinucleated giant cells.

Osteoblastic, osteoid, and chondroblastic activity and even bone formation are common in these lesions, however, less frequent than the histiocytic and fibroblastic differentiation. In the analysis of the thirty-two cases from the Armed Forces Institute of Pathology files by Guccion and Enzinger¹ there was osteoid and/or bone formation in twenty-one cases. Chondroblastic foci were observed in three cases.

Vascular invasion by tumor was not a very prominent finding and was seen only in seven cases. Metastases in these lesions mainly consist of the histiocytic and giant cells elements and occasionally of fibroblastic and osteoid components. In a recent publication⁴ a giant cell tumor of the ovary with cystadenocarcinoma which also may represent a variety of malignant giant cell tumor of soft parts was described.

The prognosis of the malignant giant tumor depends upon its location. Superficially-seated tumors may have a low grade malignancy and can be cured by local excision, while deep-seated tumors are highly malignant and need radical surgery. The poor prognosis of the deep-seated tumors seems to correlate well with the degree of anaplasia and their large size. Radiation therapy and chemotherapy is of little use and only as a palliative care of terminal patients.

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The basic pathology of partial or complete atresia of the uterine cavity is an infrequent complication of curettage following abortion or parturition. The sequence of avulsion of the endometrium, augmented by uterine packing, inflammation, and infection produces occlusive adhesions, which result in coherence of uterine and cervical musculature with ensuing menstrual vagaries, infertility, and abortion.

Asherman's Syndrome (Fritsch-Asherman)

Edward G. Waters, M.D.
Little Silver*

Asherman's syndrome is not a familiar gynecologic entity. The basic pathology of partial or complete atresia of the uterine cavity is an infrequent complication of curettage following abortion or parturition. The sequence of mechanical avulsion of the basal endometrium and myometrial elements, augmented by uterine packing, inflammation, and infection produces occlusive adhesions. These result in coherence of uterine and often cervical musculature in varying degrees with ensuing menstrual vagaries, infertility, and abortion.

The pathologic picture has been recorded under a wide variety of names,⁹ but the clinical syndrome is more often credited to Asherman, although Fritsch was the first to define and treat the pathology. Widely reported in foreign literature, this condition has received less attention in America. Romera, *et al.*¹⁸ in Venezuela recently reported a 15.4 percent incidence in 376 cases of postpartum, postabortal, and septic curettages; Jensen and Stromme¹⁰ listed only 17 cases diagnosed over a 15-year period. There are less than 25 references in the *Year Book of Obstetrics and Gynecology* during the past 25 years and five of these are from Asherman, whose 1960 report⁵ comprised 250 cases of corporeal adhesions.

In contrast, Hofmeister^{10 a} never encountered the syndrome in over 15,000 deliveries, although he employed routine postpartum intrauterine examination. Judging by Pena and Wood's¹⁷ experience, it is a common postabortal and postpartum curettage complication in South America¹⁶⁻¹⁸ which is usually referred to under such captions as "intrauterine adhesions" or

"traumatic uterine synechiae." In our experience the condition was noted only seven times, four by hystero-graphy and two (q.v.) by attempts at uterine sounding and curettage. In one amenorrheic patient with stenosed cervix and an ovarian cyst, examination of the excised uterus disclosed a fused cavity. Among more than 250,000 deliveries, over a 33-year period the diagnosis was a rarity, comparable to Hofmeister's experience.

The record of one patient depicts a classical example of the etiology, clinical history, and physical findings, as well as response to one form of treatment.

Case Report

A physician's wife, age 27, experienced a late postpartum hemorrhage following her third normal delivery. Treatment for the complication involved three curettages, uterine packs, and four blood transfusions, followed in a few weeks by prolonged illness from serum hepatitis. There was no resumption of menstruation although menses had been regular and normal prior to this complicated pregnancy.

This patient was first examined after two years of complete amenorrhea. The only physical findings of significance were a small, normally positioned uterus with complete occlusion of the uterine cavity beginning about a centimeter above the external cervical os.

With local block anesthesia an attempt was made to pass a small diameter trocharcannula upward through the cervix in the linear axis of the uterus. The insertion was made gingerly against firm resistance for 4 cm., at which point the blockage eased and 3 or 4 c.c. of thin mucoid fluid drained. A uterine sound was then passed to a resistance depth of 6 cm. Gradual but forceful dilatation to a #16 size Hegar dilator was performed and maintained for two weeks.

Ten weeks later regular cyclic menstruation began and continued. The uterus was small, mobile and the cavity 6 cm. in

*Dr. Waters is Emeritus Professor of Gynecology and Obstetrics, New Jersey Medical School, CMDNJ.

^a1973 *Yearbook Obstet and Gynec* Pp. 62-63.

depth. The scarred cervix was healed and clean. Six months later, the same findings were noted; there was also a tense left ovarian cyst which ruptured on pressure. One year after the operation, uterosalpingography demonstrated a small uterus with normal cavity and patent tubes.

The patient was seen at approximately six-month intervals for ten years. At age 40 she reported a two week delay in menstruation. Although the uterus was not enlarged, there was a positive Hegar sign and a pregnancy test was positive. She carried the pregnancy to term and delivered after three and one-half hours of labor. There was moderate postpartum bleeding due to a shallow left cervical laceration and a small succenturiate lobe which was attached to the lower uterine segment. Recovery thereafter was uneventful.

This patient with Fritsch-Asherman syndrome depicts the common etiologic factors (postpartum bleeding, repeated D and C operations, and uterine packing); the pathologic finding (endocervical-intrauterine muscular coalescence with obliteration of most of the cervix and uterine cavity); the treatment (restoration of uterine cavity, demonstration of genital tract continuity); return of functional competence (menstruation, pregnancy, parturition).

It has been suggested that legalized abortion may produce a sharp increase in this syndrome and that a reduced incidence may result from routine postpartum manual exploration and cleaning of the uterus, thereby obviating late curettage. One might assume an opposite position, for most abortions are now done under favorable conditions formerly reserved for patients with medical indications, and are recorded and accessible for review. Cautious curettage, when needed, and control of blood loss and infection after induced or spontaneous abortion should introduce results currently being experienced with postpartum complications.

Obviously, prophylaxis would be more rewarding than treatment, but treatment begins with diagnosis. A history of possible uterine trauma followed by menstrual irregularities or amenorrhea, infertility or abortions should initiate a complete genital tract survey. The means of diagnosis — sound, blunt curette, Novak aspiration curette, hystero-graphy, biopsy — in themselves provide some treatment. The cervical and uterine spatial relationships are determined, provided, and maintained by dilators, stem inserts, Foley bags, or other means.

Hormone therapy for several months, using conjugated estrogens or ethinyl estradiol and oral progestins, will promote myometrial recovery and endometrial growth and normality as evidenced by menstrual regularity. The more complete the anatomic and functional restoration, the less likely are the sequelae of sterility, abortion, and the placental accidents of abruption, accreta, and praevia. The transvaginal approach is the usual one for diagnosis and treatment. Less than ten percent of those treated required abdominal hysterectomy.

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George Franklin Fort: New Jersey's First Physician-Governor*

Two physicians have been Governors of New Jersey since elections for that office were first held in the year 1776. George Franklin Fort and William Augustus Newell [who served from 1851-54 and 1857-60 respectively] were eminent figures in the list of 45 heads of the state government over the past 190 years. Dr. Fort, a Democrat, and Dr. Newell, first Republican incumbent in the office, were elected from rural districts — one of the vast changes, political and economic, that have entered into the people's selection of their public officials during the past century.

George F. Fort, New Jersey's 16th Governor, was born at Pemberton on June 30, 1809, in a house that is still standing. At age 17 he entered the University of Pennsylvania, receiving a medical degree three years later. His doctoral thesis was entitled, *Hydro-arachnitis Infantum*. Later in the same year (1830) he became a member of The Medical Society of New Jersey.

Dr. Fort set up medical practice at New Egypt, opened a drug store and also became postmaster of the town. He was assemblyman from Monmouth County (New Egypt, now in Ocean County, was then in Monmouth) in 1844 and 1845, and senator from 1846 to 1848. While a member of the House and Senate he was a diligent member of the Judiciary Committee.

During his term in the Legislature he helped to prepare and supported the bill, passed in 1845, that provided for the establishment of New Jersey's mental hospital at Trenton, the first state institution of its kind in the United States.

Fort received the nomination for Governor at a Democratic Convention in September 1850. He campaigned on a platform for free schools, tax equalization, and abolition of the requirement that persons must own property to have the right to vote. He had the support of the United Railroad and Canal Company, a dominant political power of the day, and was elected Governor in November 1850.

Throughout his political career Governor Fort maintained an interest in medicine, practicing at intervals and accumulating a large medical library. His professional background was a boon in promoting humane care for the mentally ill and for the prisoners.

A portrait of New Jersey's first physician-governor, by an unidentified artist, hangs in the State Capitol at Trenton. Dr. Fort died at New Egypt on April 22, 1872.

*Abstracted from an historical note, authored by Fred B. Rogers, M.D., which appeared originally in *JMSNJ* (Vol. 63, No. 2, p. 68, February, 1966).

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Cancer in New Jersey: An Overview*

D.B. Louria, M.D., I. Thind, M.D., G.R. Najem, M.D.,
M.A. Lavenhar, Ph.D., R. Hamm, B.S., and E. Leming, B.A., Newark

Malignant tumors are one of the leading causes of death in the State of New Jersey. A recent comprehensive analysis of deaths in the United States 1950-1969 by county¹ placed New Jersey in the unenviable position of being considered the "cancer capital of the nation." About the time of the release of the county-by-county report by the National Cancer Institute, the Department of Preventive Medicine and Community Health of the New Jersey Medical School, under a grant from the Regional Medical Program and in collaboration with the Cancer Institute of New Jersey, developed a tumor registry. Initially, the registry collected data on incidence per 100,000 population in Newark (population 360,000) from 1970 onward. Once the data were collected from tumor registries and record rooms in Newark hospitals and in hospitals located outside Newark but used by Newark residents, similar analyses were made for Morris County (population 383,000) and Hunterdon County (population 70,000). Thus, approximately an eighth of the total population of New Jersey has been included in our studies.

There are difficulties with both studies. The national survey, now over six years old, examined and analyzed only deaths rather than deaths plus incidence (defined as the rate of occurrence of tumors over a defined period of time).

Our study is reasonably current and includes both incidence and mortality but it has a defect. In the initial phases, for reasons of convenience and budget limitations, we elected to see whether accurate reporting could be achieved by analysis of only tumor registries and record rooms. We examined incidence rates and death rates and

compared our rates with those in the 1970 national survey and in the State of Connecticut which possesses a reasonably exemplary registry; we now find what is almost certainly substantial under-reporting in nine of twenty-one major tumor categories. Consequently, all our future analyses will include examination of all pathology reports completed during the study period.

Despite these defects, a great deal of information can be gleaned from both studies. The data from our own registry will be detailed elsewhere, but that derived from the national survey plus some data on deaths with industrial causes are included herein.

National Cancer Institute Study

Table I shows that New Jersey leads the nation in deaths from malignant tumors in white males and is second nationally in deaths among white females. Death rates for black patients are among the highest twelve percent of states.

Table I
*National Ranking of Average Annual
Age-Adjusted New Jersey
Cancer Mortality Rates
1950-1969, by Race and Sex*

Race/Sex	Rate/100,000	National Rank
White Male	205.0	1
White Female	147.9	2
Black Male	230.3	6
Black Female	163.4	5

*From the Department of Preventive Medicine and Community Health, New Jersey Medical School, CMDNJ and The Cancer Institute of New Jersey. Presented at the "Seminar for Physicians: Cancer Risk Identification within New Jersey and Methods of Cancer Control", May 1-2, 1976

An analysis of specific tumors of major importance shows that New Jersey ranks first for ovarian cancers among white women, bladder malignancies among white males, and rectal cancer among females. Our state's rates are also close to the highest in intestinal cancers among white persons, lung cancer among white males, and breast cancer among white females. As emphasized in Table II, all statements about

Table II
*National Ranking of Average Annual
Age-Adjusted New Jersey
Cancer Mortality Rates
1950-1969
By Race and Sex, for Selected Sites*

Site	National Rank			
	White Male	White Female	Black Male	Black Female
Esophagus	4	5	6	13
Stomach	3	4	14	14
Colon	2	2	9	8
Rectum	2	1	5	1
Pancreas	4	3	19	24
Larynx	5	12	3	15
Lung	3	4	5	6
Breast	3	3	3	4
Cervix		43		31
Uterus		3		11
Ovary		1		6
Prostate	27		11	
Kidney	7	12	24	16
Bladder	1	5	12	6
Brain	16	15	11	10
Hodgkin's Disease	15	8	17	26
Other Lymphomas	15	24	15	6
All Sites	1	2	6	5

death rates can be interpreted properly only if information is appended about ethnicity and sex. For example, of the 10 major tumor categories in which New Jersey ranks first, second, or third nine of the 10 apply to whites and only three of the 10 relate to blacks. Similarly, New Jersey is first in bladder cancer among white men but not among white women or blacks.

Seventeen malignancies were analyzed county by county in greater detail and are listed in Table III. Since 12 of the 17 occur in both men and women, there are 29 individual categories.

We arbitrarily decided to look at counties with death rates either 50 percent above or 50 percent below the national average. Three of the major tumors showed age-adjusted death rates more than 50 percent above the national average.

Table III
Tumors Studied

Lung	Larynx
Breast	Hodgkins
Cervix	Other Lymphomas
Uterus	Pancreas
Esophagus	Kidney
Stomach	Colon
Prostate	Rectum
Nervous System	Ovary
Bladder	

These were esophagus and larynx for black men and rectum for white men and black women.

Table IV shows the counties that most often had death rates 50 percent above the national average. Three counties stand out for whites and seven counties for blacks. As can be seen in Table V, when the 21 New Jersey counties are

Table IV
*Counties in New Jersey with
Death Rates from Malignant Tumors
50 Percent Above National Average — 29 Categories
(Male and Female)*

White		Black	
Hudson	8/29	Hudson	16/29
Essex	6/29	Bergen	14/29
Passaic	5/29	Passaic	11/29
		Middlesex	11/29
		Hunterdon	11/29
		Ocean	11/29
		Sussex	11/29

Table V
*Ranking of 21 New Jersey
Counties in Regard to
Average Annual Age-Adjusted
Cancer Mortality Rates Per 100,000
1950-1969*

County	White		Non-White	
	Male Rank	Female Rank	Male Rank	Female Rank
Atlantic	10	11.5	15	16
Bergen	8	6	4	7
Burlington	14	18	17	20
Camden	6	5	12	10
Cape May	11	14	19	11
Cumberland	18	17	21	19
Essex	3	1	16	15
Gloucester	12	15	20	18
Hudson	1	2	3	6
Hunterdon	21	13	2	2
Mercer	5	11.5	18	17
Middlesex	2	4	5	5
Monmouth	9	9	14	21
Morris	20	21	10	12
Ocean	16	19	8	3
Passaic	4	7	7	9
Salem	15	10	11	14
Somerset	17	20	13	4
Sussex	19	16	1	1
Union	7	3	9	13
Warren	13	8	6	8

compared with each other in regard to death rates, Hudson, Bergen, Passaic and Middlesex rank in the top 10 New Jersey counties in all four categories (white male, white female, black male, black female). County cancer death rates 50 percent below the national average occurred far less frequently than death rates at least 50 percent greater than the national average. This is summarized in Table VI. For whites, there were

Table VI
*Total Counties with Malignant Tumor Death Rates
1950-1969
50 Percent Greater or Less Than National Average*

	White	Black
--	-------	-------

Tumor Death Rates 50% Greater than National Average	42/609 (7%)	176/527 (34%)
Tumor Death Rates 50% Less than National Average	7/609 (1%)	12/527 (2.5%)

Denominator = Counties × Tumors

609 possible instances of tumor rates greater or less by 50 percent than the national average (29 tumor categories multiplied by 21 counties). In seven percent, rates were substantially increased as contrasted to one percent in which they were substantially less than the national average by our arbitrary criteria. In some counties the denominator for blacks is smaller because the small number of blacks and the small number of deaths precluded establishing rates. In approximately a third of the individual determinations, rates were more than 50 percent greater than the national average and in 2.5 percent of the 527 individual determinations, rates were smaller by at least 50 percent.

These tables indicate that New Jersey ranks first to sixth in death rates among whites and blacks, not because the state has fantastically high rates in a large number of specific categories, but because, in general, the state of New Jersey is somewhat above the national average in a great many individual categories and far less often below the national average. A review of the above tables shows an intriguing pattern. As shown in Tables IV and V, only one of the counties with inordinately high rates among blacks and whites is located among the eight southern New Jersey counties; the other high rate coun-

ties are found in northern New Jersey. Similarly, when New Jersey counties are ranked by comparative death rates, the northern counties generally show higher rates than southern New Jersey counties. Thus, to a large extent the excessive New Jersey mortality appears to be concentrated in the 13 northern counties. The reasons for these findings are not yet clear.

Using the 1950-1969 county survey, we have calculated the number of excess deaths per year using the 1970 census and then applying these figures to the anticipated deaths from cancer in New Jersey in 1976² (see Table VII). Obviously,

Table VII
*Death Rates All Malignant Neoplasms
New Jersey 1950-1969*

		Increase Over Rank National Average	Number of Excess Deaths per year (approx.)*
White Male	1st	30/100,000	930
White Female	2nd	18/100,000	600
Black Male	6th	46/100,000	160
Black Female	5th	24/100,000	100
	Total		1,790

*using 1970 census data

if one uses 1950-1969 death rates, the 1970 population and 1976 expected deaths, it is imperative to emphasize that any resultant calculations are only rough approximations. Nevertheless, it seems reasonable to us to suggest that of the estimated 14,600 deaths in 1976 about one in eight represents excess New Jersey mortality; if we could reduce our rate to the national average, some 2,000 persons would not die in 1976.

Industry and Malignancy

The final table refers to the problem of malignancies related to industry. It has been said that over 80 percent of cancer is environmentally caused, and this has been interpreted to mean that most cancer in New Jersey is related to industrial exposure. That would seem to be an over-simplification according to present knowledge. Of the major tumors, the only ones clearly related to industrial exposure are bladder, larynx, leukemia, kidney, stomach, and lung (see Table VIII). For the most part, the in-

Table VIII
Industry-Related Malignancies

<i>Related to Exposure</i>	<i>Relationship Unproved</i>	
<i>Estimated Percent</i>		
Bladder <33%	Breast	Esophagus
Lung <10%	Cervix	Stomach
Kidney <10%	Lung (>90%)	Colon
Larynx <10%	Prostate	Rectum
Stomach <10%	Uterus (Corpus)	Pancreas
	Ovary	Lymphoma

dustrial exposure is a secondary co-factor, as in lung cancer for instance. No more than 10 percent of lung cancer can be ascribed to industrial exposure; similarly, only a minority of cases of the other five tumors can be related to industrial exposure. Table VIII shows a rough estimate of the percentage of cases yearly that can be ascribed to industrial exposure.

Using these figures it would appear that only about 700, or five percent, of the estimated 1976 cancer deaths in New Jersey can be attributed to industrial exposure. Though the present limited data permit the unequivocal attribution to industry of only a small percentage of New Jersey cancers, circumstantial evidence indicates that a much larger proportion may be so related. The geographic pattern of cancer mortality in New Jersey — the predominance in the northern counties — strongly suggests that environmental contamination by industry may play an important role in tumor induction in this State. Such a role may, in fact, be quite likely, since many chemicals emitted in industrial operations can serve as pro-carcinogens, or direct-acting carcinogens in the complex etiology of cancer.

What Must Be Done

It seems to us that the national county study and our preliminary results, which will be summarized elsewhere, clearly show the need for precise data about cancer in the State of New

Jersey. If this is to take place, the following must be done:

(a) There must be a state-wide registry that includes information on incidence and mortality for each malignant tumor.

(b) The reporting of cancer will have to be mandatory.

(c) The collected data will have to be available to every legitimate scientific group attempting to focus on specific tumor problems.

(d) The state legislature will have to provide funds for the state registry; if these monies are not made available, then legislators will have no right to bewail the severity of the problem with fustian rhetoric.

(e) Hospital record rooms will have to be standardized and, in many instances, upgraded; it is not until a study such as this is made that one realizes how many record rooms are kept in exemplary fashion and how many range from moderately to appallingly inadequate. With our impressive technologic capacities in the areas of record keeping and data recall, there is no excuse for anachronistic or inept record-keeping practices.

(f) As registry information points out specific areas requiring intensive investigation, mechanisms for providing funds for the derivative studies will have to be readily available through a state-wide funding unit.

References

1. Mason TJ and McKay FW: United States cancer mortality by county — 1950-1969. U.S. Dept. Health, Education and Welfare Pub. Health Service, Nat. Inst. Health, Nat. Cancer Inst. Bethesda, Md. DHEW Pub # (NIH 74-615).
2. Cancer Statistics 1976: *Ca* 26: 14-29, 1976.

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See Department of Health report on "Cancer in New Jersey" in October issue.

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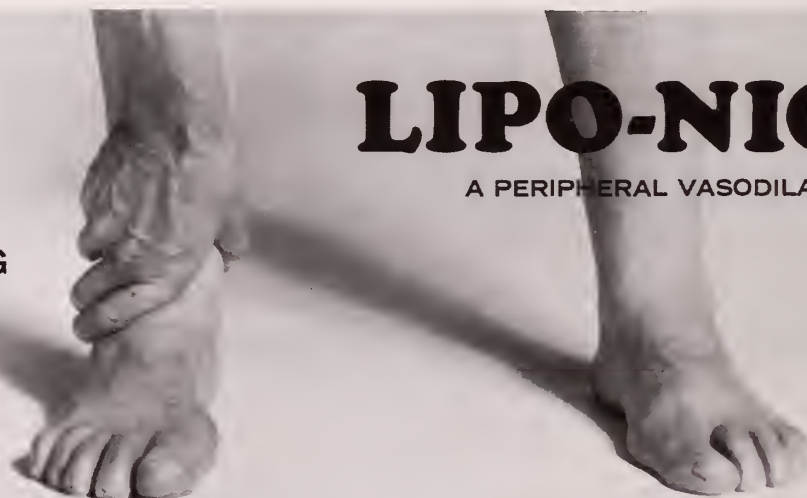
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NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes

July 18, 1976

A regular meeting of the Board of Trustees was held on Sunday, July 18, 1976, at the Executive Offices, Trenton. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

Limitations on Hospital Inpatient and Routine Service Costs Under Medicare . . . Received a report from the Executive Director that there appeared in the June 30, 1976 *Federal Register* a rule which would place limitations on hospital inpatient services and routine service costs under Medicare. The AMA position on this rule is not definitive and a decision has not been made as to whether litigation will be instituted.

AMA Membership . . . Directed that: (a) physicians who are not members of the AMA be contacted by either the President or Chairman of the New Jersey Delegation to the AMA, apprised of the values of AMA membership, and urged to join; and (b) that component societies be urged to begin an ongoing AMA membership drive and, when billing physicians for dues, that the AMA dues portion not be listed as "optional" as some counties have done in the past.

Note: The above action was precipitated by the fact that AMA membership in New Jersey has dropped considerably and unless it can be increased by 1300 physicians, we will lose two delegates and two alternate delegates. Bergen County Medical Society has recently conducted a successful program on AMA membership in which representatives of the AMA participated. Essex County is planning a similar program.

Chiropractors Requesting Radiological Examination . . . Directed that the Executive Director respond to the Board of Medical Examiners request for a position statement on physicians refusing to make radiologic examinations for persons referred to them by chiropractors, reiterating that it is recognized in medicine and in law that physicians may determine for themselves to whom they will render their ser-

vices, and pointing out that the examinations requested by chiropractors are beyond the scope of a chiropractic license and therefore inappropriate.

Conference-Workshop on Radiation-Associated Thyroid Neoplasms . . . Authorized John J. Thompson, M.D., to attend (with expenses paid) the Conference-Workshop on Radiation-Associated Neoplasms, to be held September 30 and October 1 in Chicago.

Professional Liability Insurance . . . Received a report from the Executive Director concerning the public hearing held by the Insurance Department on Chubb's rate filing for MSNJ's professional liability insurance premiums. The Public Advocate took the position that the rate filing was actuarially sound and there was no quarrel with allocations or classes. The Chief Actuary for the Department of Insurance stated that all questions were answered to his satisfaction.

In later discussions with Dr. George, MSNJ's representative at the hearing, it was revealed that the conclusion reached was that Chubb might seek to have the State Reinsurance Facility invoked. This action would be taken because Chubb's Board policy restricts its professional liability underwriting to five percent of overall premium underwriting and MSNJ's current policy exceeds that and will most likely continue to do so, especially if the proposed rate filing is approved.

The Executive Director will communicate with Chubb, thanking them for their cooperation and requesting information on whether Chubb plans to continue to underwrite MSNJ's professional liability insurance and the possibility of activation of the Reinsurance Facility.

Radiologists' Lawsuit . . . Voted to urge Blue Shield to adopt a position opposing that of Blue Cross and actively to participate in a lawsuit whose issue is whether radiologists have the right to be considered fee-for-service practitioners.

Should the suit be decided against the radiologists, Blue Cross coverage would be expanded to include physician services, and the demise of Blue Shield as an insuring entity of in-hospital physician services would be a real probability.

Annual Meeting† . . . Approved a report of the Committee on Annual Meeting, including the following recommendations:

1. That the 212th Annual Meeting be held in Chalfonte-Haddon Hall, May 12-16, 1978, contingent upon the success or failure of the 1977 convention.
2. That a convention aboard a cruise ship or in Bermuda is impractical; and further that MSNJ not consider moving the Annual Meeting out-of-state at this time.
3. That beginning with the 1977 convention, honoraria and expenses in connection with the scientific sessions be limited to out-of-state guest-speakers only; non-member New Jersey-speakers are not to be considered in the category of "guest-speaker."

Joint Executive Committee Meeting between MSNJ and NJHA . . . Approved a report of the Executive Committee concerning its meeting with the New Jersey Hospital Association where the following items were discussed:

1. Blue Cross-Blue Shield coverage of outpatient procedures (to be followed up with a request for a joint meeting with the Plans).
2. Actions of MSNJ's House of Delegates.
3. Items of legislative concern and medical-legal significance.
4. The next joint meeting — scheduled for September 1, 1976, at 9:30 a.m., at the New Jersey Hospital Association.

MSNJ Executive Committee . . . Approved the following report of June 16 meeting of the Executive Committee:

1. A-New Jersey Influenza Vaccine — the President summarized the planned inoculation program. The Committee further directed that topical information be supplied to the membership via a newsletter or special mailing in July or August.
2. Nominations to the State Board of Medical Examiners — this item was referred to the Executive Committee by the Board. The Committee directed that the following nominations be submitted to the Governor in alphabetical order: Harry W. Fullerton, M.D. (Salem); Eric J. Lazaro, M.D. (Hudson); William Pomerantz, M.D. (Morris).

†In accordance with the action of the House of Delegates authorizing the Annual Meeting Committee to select the site of the 1977 annual meeting, the decision has been made to return to Haddon Hall, Atlantic City, May 13-17.

3. Temporary Limited Licenses — reviewed and accepted the report from Drs. Rogers and Bergen on this topic and referred it to the State Board of Medical Examiners.

4. 1977 Annual Meeting — received a report from Dr. Gardam that Haddon Hall is available during the third week of May 1977.

5. No-Fault Insurance — referred to the Ad Hoc Committee on Professional Liability development of a compensation system for non-negligent medical injuries.

6. Support of "Family Week" — voted to support a resolution signed by President Ford declaring November 21-27 "Family Week."

AMA Annual Convention . . . Took the following actions on the summary report of the AMA Annual Convention:

1. Approved the President's request that MSNJ obtain from the AMA a film for physicians on "How to Conduct Yourself Before the Press." This film will be shown at the Fall Conference of Presidents and Presidents-Elect while in session with the Board of Trustees in October.
2. Voted to congratulate Emanuel M. Satulsky, M.D., New Jersey's long-standing Delegate and former State President, on his election to the AMA Council on Constitution and Bylaws.
3. Directed that a communication be sent to component societies requesting that they form intern and resident committees at the local hospital level.
4. Directed staff to publicize the fact that MSNJ frowns upon the common practice of severe and rapid weight loss in amateur wrestling.

Swine Influenza Immunization Program . . . Approved the following recommendation from the Council on Public Health and directed that it be called to the attention of the component societies:

That any further dissemination of information in regard to the Swine Influenza Immunization Program be held in abeyance until the Council has received more specific information from Dr. Goldfield in the Department of Health.

Note: As soon as information is received from the Department of Health, a special meeting of the Council will be scheduled and recommendations will be forwarded to the Board of Trustees.

Professional Liability Program . . . Approved the following recommendation from the Committee on Medical Defense and Insurance concerning re-evaluation of a request to increase amount authorized in settling non-defensible claims:

That the defense attorney should inform the physician as to the outcome of the review and the reasons it was either deemed defensible or non-defensible.

Note: This information will be given verbally to the defendant physician by the attorney assigned to the case who can answer the legal technical questions, but it does not relieve Chubb and Son from sending notice in writing.

Payment by Blue Shield for Medical Consultation in Consultant's Office . . . Received a statement from Charles L. Cuniff, M.D., Vice President-Medical Affairs, Blue Shield of New Jersey, concerning Resolution #11 of the 1974 House of Delegates and Resolution #30 of the 1975 House of Delegates, dealing with payment by Blue Shield for medical consultations in the office. Blue Shield has agreed to conduct a pilot study to ascertain the feasibility of providing such coverage on a statewide basis. The pilot study would enable Blue Shield to develop structural guidelines to insure against misuse of this service if provided statewide.

Medical School in South Jersey . . . Voted not to take action concerning the allegations of Drs. Marvin and Jeffrey Solomon (Cumberland County) that the creation of a medical school in South Jersey would be contrary to the advice of the Medical Task Force, Rutgers Medical School, and the Basic Science Faculty in Newark.

Note: Reports and communications supporting this allegation were supplied to the Board and will be reviewed for discussion at the next meeting.

Clinical Laboratory Improvement Act . . . Noted that the AMA has requested physicians in a position to do so to contact James J. Florio, Andrew McGuire, and Matthew J. Rinaldo and to urge them to vote against HR-11341, the Clinical Laboratory Improvement Act, and in favor of the amendments proposed by the AMA.

Report from the Foundation

Daniel J. O'Regan, M.D., Medical Director

The Federal Register of July 26 carried the news that the Secretary of HEW will proceed to enter into an agreement with the Essex Physicians' Review Organization, Inc., designating it as the PSRO for Area IV of the State of New Jersey. This is a most satisfactory resolution of a problem which occurred after the initial publica-

tion of the intention to designate "EPRO" as a Conditional PSRO, which appeared on March 25, 1976. There followed a "notification and polling" process. Physicians practicing in the area, who felt that EPRO should not be designated as Conditional were requested to notify the Secretary. If more than 10 percent objected, the Secretary would then have been obligated to conduct a poll of all the physicians. If 25 percent or more objected, the Secretary then could not have designated EPRO. This process is required by the PSRO law, and is carried out whenever a Planning PSRO has been deemed ready to assume Conditional status.

Unfortunately, in the case of Area IV of New Jersey, an error was made (by the consulting firm used by HEW for the purpose) as to the number of doctors of medicine and osteopathy practicing in Essex County. Thus it was not possible to determine what was ten percent, and it was necessary to repeat the procedure, beginning on June 1, with a 30-day response period. The process is now complete. There was not a ten percent sample of physicians objecting to EPRO and the Essex group can begin review. Again we congratulate Dr. Arthur Bernstein, President, and his group for their good work, and also for their patience during the recent delays.

There are now three Conditional PSROs in New Jersey — Area I (Morris, Sussex, Warren), II (Passaic), and IV (Essex). Our State thus becomes eligible for the creation of a State Professional Standards Review Council.

The experience has reminded all of us of a few basic facts: (1) do not assume that what seem to be fairly straight-forward facts — such as, how many doctors there are in a county — are readily available, or accurate, (2) if you do not have an accurate starting point — in any type of measuring activity — your conclusions cannot be valid, and (3) the old adage of the carpenter: "measure twice, cut once," is still a good one.

Comparable baselines — of the number of doctors, lengths of stay, available beds, percentage of specialists, and so on — are necessary to all programs which will survey medical care.



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Informed Consent

All too often physicians are concerned about whether they have received "informed consent" from their patients for surgery or even routine care. They fear suit from the patient in the event such a "consent" has not been received. This article will discuss briefly what the law of New Jersey seems to require of a physician in this area of consent.

The general rule followed in New Jersey courts is that a physician has a duty to disclose to his patient what a reasonable medical practitioner in that specialty would disclose to a patient under same or similar circumstances. It is the patient who sues who has the burden of proving that his physician did not make such a disclosure. He must offer proof from a physician that the doctor being sued failed to make the required disclosure.

A court of this State has held that there is "no definite yardstick by which there can be an exact determination that a surgeon has surpassed the consent of the patient." It is generally agreed that the nature and extent of the disclosure, essential to an informed consent, depends upon the medical problem as well as the patient.

"Informed consent" cases, thus, must consider whether the warnings given satisfied the doctor's duty to his patient. This sometimes turns into a contest between the opposing expert witnesses as to what warnings are given routinely in cases of the type being tried. The relative experience of these experts plays an important part in resolving this issue. It is more reasonable to expect a jury to believe testimony given by neurosurgeons in neurosurgical "informed consent" cases than that offered by a psychiatrist or radiologist.

Often, however, "informed consent" cases do not turn on disputes of whether the warnings given were sufficient, but whether any warnings at all were given. This then reduces the case to a contest between the patient and the physician as to who said what.

In such cases the physician substantially helps his case if he has obtained a written consent from the patient which described the procedure to be done and those risks customarily told to patients in procedures of that type. While such a written consent is not conclusive it makes it extremely difficult for the patient to deny that any warnings were given or that the procedure was done without his permission.

The clearer the language of the written consent, the better the physician's chance of winning the case. Print which can be read only through a magnifying glass should be avoided. The courts and the juries do not seem to take well to small print.

There is an increasing trend — and a healthy one — that patients must prove that they would have refused to undergo the treatment had they been given the warnings their expert witness said were customarily given in cases of this type. The theory supporting this trend seems to be that a patient should not be able to have his cake and eat it too.

In short, if you are practicing good medicine when you obtain your patient's consent to a procedure, you are probably practicing good law as well.

CMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President, CMDNJ

September, 1977, will mark the figurative opening of a new medical school in New Jersey, the state's third. It will be known as The New Jersey School of Osteopathic Medicine of the College of Medicine and Dentistry of New Jersey (CMDNJ).

There will be no school building, as such, although there will be a site in Camden to house the school's dean, an associate dean for clinical affairs, and an assistant dean for student affairs. There probably will be 24 students in the first

academic year, with an equal number admitted each succeeding year until the total student body reaches 96. Students in the osteopathic program will take their first two basic-science years at existing facilities of the College, where a department of osteopathic principles and practices will probably be domiciled. These students then will move to the Camden area for clinical rotations at Kennedy Hospital in Stratford, the Cherry Hill Medical Center, and other facilities.

Allopathic students for South Jersey, approximately 20 to 30 each year, will be selected from the existing enrollment of CMDNJ-Rutgers Medical School and assigned to the Cooper Medical Center, Camden for their clinical years. Eventually, it is hoped, some will study at the Veteran's Administration Hospital which has been approved for construction on a site adjoining Cooper. This program will be headed by an associate dean assisted by chiefs of clinical departments at Cooper.

CMDNJ-Rutgers Medical School — once a two-year, basic-science school — is now a four-year institution. At present, only half of the third and fourth year classes remain in our State. The South Jersey program will mean that about half of those who otherwise would have to transfer out of the state may complete their medical education in New Jersey. Thus, the potential for alleviating the shortage of practicing physicians, especially in the southern counties, will be greatly increased.

The South Jersey Medical Education Program, which has been at least a decade in the making, finally became possible two years ago when the Legislature appropriated funds for a planning office in Camden and recently assured a \$600,000 appropriation for the current fiscal year. This will permit implementation of earlier planning, the selection of deans, administrative personnel and clinical faculties, the preparation of affiliation agreements with the appropriate hospitals, and the initiation of the accrediting procedures.

Both the osteopathic and the third and fourth year allopathic programs were mandated by the State Legislature last year, but the lawmakers failed to provide funding. That omission has now

been remedied through the efforts of South Jersey's legislators, physicians and hospitals of the area, and the leadership of the College's South Jersey Community Advisory Council.

The New Jersey School of Osteopathic Medicine will be assisted with start-up funds which are earmarked by the U.S. Department of Health, Education and Welfare, for new medical schools only. The grant application for \$840,000 to cover a four-year period was submitted early this year. A positive report resulted from an HEW site visit, so all indications point to an award to develop an administrative structure, admissions procedures, and a distinct budget which will meet Federal requirements. A site visit from the accrediting body of the American Osteopathic Association is expected early in the fall.

This status report may fail to convey the planning, the work, the debates, and the obstacles that have marked the road to what now seems to be success. However, the State Legislature has made another major commitment to medical education.

Analysis of Eye Health Screening Programs* 1957-1975

Year	Total Screened	Total Negative	Total Positive	Tonometry Suspects
1957	4,062	3,106	956	260
1958	5,627	3,211	2,416	328
1959	4,784	2,392	2,392	298
1960	5,496	2,827	2,669	362
1961	7,426	3,995	3,431	405
1962	7,758	3,883	3,875	529
1963	8,157	4,402	3,755	467
1964	12,892	7,108	5,784	684
1965	10,899	6,043	4,856	532
1966	7,402	3,876	3,526	404
1967	10,620	5,946	4,674	576
1968	11,659	6,416	5,243	561
1969	11,114	5,939	5,175	464
1970	10,986	6,085	4,901	456
1971	12,481	7,169	5,312	520
1972	12,854	7,155	5,699	593
1973	10,883	6,077	4,806	579
1974	11,447	6,473	4,974	546
1975	10,522	5,832	4,690	575
Total	177,069	97,935	79,134	9,139

*Sponsored by MSNJ.

Recommended Treatment Schedules for Syphilis (1976)

The following recommendations were established by the Venereal Disease Control Advisory Committee, Ralph H. Henderson, M.D., Chairman, after deliberation with therapy experts.*

Few data have been published on the treatment of syphilis since CDC revised these recommendations in 1968. Penicillin continues to be the drug of choice for all stages of syphilis. Every effort should be made to document penicillin allergy before choosing other antibiotics because these antibiotics have been studied less extensively than penicillin. Physicians are cautioned to use no less than the recommended dosages of antibiotics.

Early Syphilis (primary, secondary, latent syphilis of less than one year's duration)

(1) Benzathine penicillin G — 2.4 million units total by intramuscular injection at a single session. Benzathine penicillin G is the drug of choice because it provides effective treatment in a single visit; OR

(2) Aqueous procaine penicillin G — 4.8 million units total; 600,000 units by intramuscular injection daily for 8 days; OR

(3) Procaine penicillin G in oil with 2% aluminum monostearate (PAM) — 4.8 million units total by intramuscular injection; 2.4 million units at first visit, and 1.2 million units at each of two subsequent visits 3 days apart. Although PAM is used in other countries, it is no longer available in the United States.

Patients who are allergic to penicillin:

(1) Tetracycline hydrochloride† — 500 mg 4 times a day by mouth for 15 days; OR

(2) Erythromycin (stearate, ethylsuccinate or base) — 500 mg 4 times a day by mouth for 15 days.

These antibiotics appear to be effective but have been evaluated less extensively than penicillin.

Syphilis of More Than One Year's Duration (latent syphilis of indeterminate or more than 1 year's duration, cardiovascular, late benign, neurosyphilis)

(1) Benzathine penicillin G — 7.2 million units total; 2.4 million units by intramuscular injection weekly for 3 successive weeks; OR

(2) Aqueous procaine penicillin G — 9.0 million units total; 600,000 units by intramuscular injection daily for 15 days.

The optimal treatment schedules for syphilis of greater than one year's duration have been less well established than schedules for early syphilis. In general, syphilis of longer duration requires higher-dose therapy. Although therapy is

recommended for established cardiovascular syphilis, there is little evidence that antibiotics reverse the pathology associated with this disease.

Cerebrospinal fluid (CSF) examination is mandatory in patients with suspected, symptomatic neurosyphilis. This examination is also desirable in other patients with syphilis of greater than one year's duration to exclude asymptomatic neurosyphilis.

Published studies show that a total dose of 6.0 to 9.0 million units of penicillin G results in a satisfactory clinical response in approximately 90 percent of patients with neurosyphilis. There is more published clinical experience with short-acting penicillin preparations than with benzathine penicillin G. Some clinicians prefer to hospitalize patients with neurosyphilis, particularly if the patient is symptomatic or has not responded to initial therapy. In these instances they treat patients with 12 to 24 million units of aqueous crystalline penicillin G given intravenously each day (2 to 4 million units every 4 hours) for 10 days.

Patients who are allergic to penicillin:

(1) Tetracycline hydrochloride — 500 mg 4 times a day by mouth for 30 days, or

(2) Erythromycin (stearate, ethylsuccinate or base) — 500 mg 4 times a day by mouth for 30 days.

There are no published clinical data which adequately document the efficacy of drugs other than penicillin for syphilis of more than one year's duration. Cerebrospinal fluid examinations are highly recommended before therapy with these regimens.

Syphilis in Pregnancy — Evaluation of Pregnant Women

All pregnant women should have a nontreponemal serologic test for syphilis, such as the VDRL or RPR test, at the time of the first prenatal visit. The treponemal tests such as the FTA-ABS test should not be used for routine screening. In women suspected of being at high risk for syphilis, a second nontreponemal test should be performed during the third trimester. Seroreactive patients should be evaluated expeditiously. This evaluation should include a history and physical examination, as well as a quantitative nontreponemal test and a confirmatory treponemal test.

If the FTA-ABS test is nonreactive and there is no clinical evidence of syphilis, treatment may be withheld. Both the quantitative nontreponemal test and the confirmatory test should be repeated within 4 weeks. If there is clinical or serologic evidence of syphilis or if the diagnosis of syphilis cannot be excluded with reasonable certainty, the patient should be treated as outlined below.

Patients for whom there is documentation of adequate treatment for syphilis in the past need not be retreated unless there is clinical or serologic evidence of reinfection such as darkfield-positive lesions or a four-fold titer rise of a quantitative nontreponemal test.

*Dr. Henderson is also Director of Venereal Disease Control Division, Center of Disease Control, Atlanta.

†Food and some dairy products interfere with absorption. Oral forms of tetracycline should be given 1 hour before or 2 hours after meals.

a. For patients at all stages of pregnancy who are not allergic to penicillin: Penicillin in dosage schedules appropriate for the stage of syphilis as recommended for the treatment of nonpregnant patients.

b. For patients of all stages of pregnancy who are allergic to penicillin: Erythromycin (stearate, ethylsuccinate or base) in dosage schedules appropriate for the stage of syphilis, as recommended for the treatment of non-pregnant patients. Although these erythromycin schedules appear safe for mother and fetus, their efficacy is not well established. Therefore, the documentation of penicillin allergy is particularly important before treating a pregnant woman with erythromycin. Erythromycin estolate and tetracycline are not recommended for syphilitic infections in pregnant women because of potential adverse effects on mother and fetus.

Follow-up — Pregnant women who have been treated for syphilis should have monthly quantitative nontreponemal serologic tests for the remainder of the current pregnancy. Women who show a four-fold rise in titer should be retreated. After delivery, follow-up is as outlined for non-pregnant patients.

Congenital Syphilis

Congenital syphilis may occur if the mother has syphilis during pregnancy. If the mother has received adequate penicillin treatment during pregnancy, the risk to the infant is minimal. However, all infants should be examined carefully at birth and at frequent intervals thereafter until nontreponemal serologic tests are negative.

Infected infants are frequently asymptomatic at birth and may be seronegative if the maternal infection occurred late in gestation. Infants should be treated at birth if maternal treatment was inadequate, unknown, with drugs other than penicillin, or if adequate follow-up of the infant cannot be ensured.

Infants with congenital syphilis should have a CSF examination before treatment.

Infants with abnormal CSF:

(1) Aqueous crystalline penicillin G, 50,000 units/kg intramuscularly or intravenously daily in 2 divided doses for a minimum of 10 days, OR

(2) Aqueous procaine penicillin G, 50,000 units/kg intramuscularly daily for a minimum of 10 days.

Infants with normal CSF:

Benzathine penicillin G, 50,000 units/kg intramuscularly in a single dose. Although benzathine penicillin has been previously recommended and widely used, published clinical data on its efficacy in congenital neurosyphilis are lacking. If neurosyphilis cannot be excluded, the procaine or aqueous penicillin regimens are recommended. Since cerebrospinal fluid concentrations of penicillin achieved after benzathine

penicillin are minimal to nonexistent, these revised recommendations seem more conservative and appropriate until clinical data on the efficacy of benzathine penicillin can be accumulated. Other antibiotics are not recommended for neonatal congenital syphilis.

Penicillin therapy for congenital syphilis after the neonatal period should be with the same dosages used for neonatal congenital syphilis. For larger children the total dose of penicillin need not exceed the dosage used in adult syphilis of more than one-year's duration. After the neonatal period, the dosage of erythromycin and tetracycline for congenital syphilis who are allergic to penicillin should be individualized but need not exceed dosages used in adult syphilis of more than one-year's duration. Tetracycline should not be given to children less than 8 years of age.

Follow-up and Retreatment

All patients with early syphilis and congenital syphilis should be encouraged to return for repeat quantitative nontreponemal tests 3, 6, and 12 months after treatment. Patients with syphilis of more than one year's duration should also have a repeat serologic test 24 months after treatment. Careful follow-up serologic testing is particularly important in patients treated with antibiotics other than penicillin. Examination of CSF should be planned as part of the last follow-up visit after treatment with alternative antibiotics.

All patients with neurosyphilis must be carefully followed with serologic testing for at least 3 years. In addition, follow-up of these patients should include clinical re-evaluation at 6-month intervals and repeat CSF examinations, particularly in patients treated with alternative antibiotics.

The possibility of reinfection should always be considered when retreating patients with early syphilis. A CSF examination should be performed before retreatment unless reinfection and a diagnosis of early syphilis can be established.

Retreatment should be considered when: (1) clinical signs or symptoms of syphilis persist or recur; (2) there is sustained four-fold increase in the titer of a nontreponemal test; or (3) an initially high-titer nontreponemal test fails to show a four-fold decrease within a year.

Patients should be retreated with the schedules recommended for syphilis of more than one year's duration. In general, only one retreatment course is indicated because patients may maintain stable, low titers of nontreponemal tests or have irreversible anatomical damage.

Epidemiologic Treatment

Patients who have been exposed to infectious syphilis within the preceding three months and other patients who on epidemiologic grounds are at high risk for syphilis should be treated as for early syphilis. Every effort should be made to establish a diagnosis in these cases.

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PHYSICIANS SEEKING LOCATION IN NEW JERSEY

The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

FAMILY PRACTICE — Shiv N. Radtogi, M.D., 1641 Third Avenue, Apt. 12-E, New York 10028. S.N. Medical College, Agra (India). Also general surgery. Group, partnership, or solo. Available.

Harry Collins, M.D., 380 Maple Avenue West, Vienna, Virginia 22180. Hahnemann 1974. Board eligible. Group or ER in southern New Jersey. Available.

Jonathan B. Tocks, M.D., 1315 Strafford Road, Camp Hill, Pa. 17011. Michigan 1973. Group. Available July 1977.

Gary M. Cummins, M.D., 124 Oak Ridge Drive, York, Pa. 17400. Pittsburgh 1974. Board eligible. Available July 1977.

GASTROENTEROLOGY — Robert D. Fusco, M.D., 1416 Wyldewood Road, Durham, North Carolina 27704. University of Pittsburgh 1973. Board eligible. Group or partnership. Available July 1977.

INTERNAL MEDICINE — Ashok Kumar, M.D., 345 Bronx River Road, Apt. 7-C, Yonkers, New York 10704. SMS Medical (Jaipur, India) 1967. Board certified. Group, partnership, or solo. Available.

Stephen Winograd, M.D., 208 Walnut Street, Montclair 07042. NYU 1972. Subspecialty, gastroenterology. Board certified. Solo, partnership, group. Available July 1, 1977.

Jeffrey I. Selwyn, M.D., 711 Pampa Place, Tucson, Arizona 85704. SUNY, Downstate 1972. Board certified. Group or partnership. Available January 1977.

Gene H. Ginsberg, M.D., 1735A Clarion Loop, Cannon AFB, Clovis, New Mexico 88101. Jefferson 1972. Board certified. Group, partnership or association, solo. Available July 1977.

Elihu J. Goren, M.D., 5509 Greentree Road, Bethesda, Maryland 20034. Einstein 1973. Subspecialty, endocrinology. Board eligible. Group or partnership. Available July 1977.

Fred H. Hyer, M.D., 6640 SW Fifth St., Pembroke Pines, Fla. 33023. CMDNJ 1970. Subspecialty, rheumatology. Board eligible. Group, partnership, or solo. Available July 1977.

Joseph L. Verdirame, M.D., 200 Carman Ave., Apt. 6-G, East Meadow, New York 11554. Virginia 1974. Group. Available July 1977.

John S. Zesk, M.D., 56 Castleman Rd., Rochester, New York 14620. Rochester 1970. Subspecialty, cardiology. Board certified (IM). Group, clinic, or partnership. Available July 1977.

OBSTETRICS AND GYNECOLOGY — Narendra D. Karmali, M.D., 753 Classon Avenue, Apt. 2-D, Brooklyn, New York 11238. T. N. Medical (Bombay, India) 1970. Board eligible. Group, partnership. Available.

OCCUPATIONAL MEDICINE — Alexander A. Boytar, M.D., 3101 Skyline Dr., Wilmington, De. 19808. Budapest 1947. Board certified — (IM). Industrial medicine, pharmaceutical or chemical company, group of industrial physicians. Available.

PATHOLOGY — Azhar Saifuddin, M.D., Cambridge Arms Apts., Route 9, Box 644-A, Florence, Alabama 35630. Dow Medical College, Karachi (Pakistan) 1966. Board certified. Group, partnership, solo. Available.

Him G. Kwee, M.D., 207 Duke of York Lane, Apt. T-1, Cockeysville, Md. 21030. Airlangga (Indonesia) 1964. Group. Available July 1977.

PEDIATRICS — David Spiller, M.D., 401 East 86th Street, Apt. 11-K, New York 10028. New York Medical College 1972. Board eligible. Solo. Available.

Stewart Gabel, M.D., 5805 Tivoli Circle, Richmond, Virginia 23227. Albert Einstein 1968. Board eligible. Group or hospital setting. Available.

Mark B. Levin, M.D., 5100 Highbridge St., Apt. 505, Fayetteville, New York 13066. SUNY (Syracuse) 1974. Group, partnership, solo. Available July 1977.

Elizabeth W. Dow, M.D., 3705-B, Woodmont Blvd., Nashville, Tenn. 37215. Vanderbilt 1972. Board eligible. Special interest in adolescence. Group, student health service, partnership, hospital. Available October 1, 1976.

SURGERY — Henry H. Bard, M.D., 10 Medical Plaza, Glen Cove, New York 11542. Columbia 1948. Board certified. Partnership, full time. Available.

David L. Walrath, M.D., 12 Polo Lane, Westbury, New York 11590. CMDNJ (Newark) 1970. Partnership or small group. Available July 1977.

UROLOGY — David H. Kauder, M.D., 4016 Grimes Avenue, South, Edina, Minnesota 55416. SUNY, Downstate 1971. Board eligible. Group or partnership. Available June 1977.

Stephan Jay Sweitzer, M.D., 350 Curtin Drive, Lexington, Kentucky 40503. Vanderbilt University 1970. Board eligible. Group or association leading to partnership. Available July 1977.

Stanley M. Bernstein, M.D., 350 W. 57th St., Apt. 4-G, New York 10019. NYU 1968. Board eligible. Any type of practice. Available January 1977.

Syed S. Mada, M.D., 260-18 73rd Avenue, Glen Oaks, New York 11004. Punjab (Pakistan) 1967. Board eligible. Any type of practice. Available July 1977.

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Therapeutic Drug Information Center*

The Schwartz Inter-National Pharmaceutic and Therapeutic Drug Information Center of the Brooklyn College of Pharmacy, Long Island University, compiles the information contained in this column each month. The Center serves as a source of intelligence on therapeutic and pharmaceutical information not readily available to physicians, at no charge to them, and provides this information with minimal time involvement. It is staffed by trained pharmacists; Jack M. Rosenberg, Pharm. D., Associated Professor and Chairman, Division of Clinical Pharmacy, Brooklyn College of Pharmacy, is Director and Walter Modell, M.D., Emeritus Professor of Pharmacology at Cornell University Medical College, is pharmacologist consultant. The service is available Monday through Friday from 9 a.m. to 4:30 p.m. — telephone (212) 622-8989 or 636-7535. The following are questions and answers handled by the Center recently.

1. Please supply information about the use of clonidine in migraine.

Clonidine (Catapres®) is an imidazoline derivative used for the treatment of hypertension. Its use in the prophylaxis and treatment of migraine was initiated after the observation of Zaimis and Hanington¹ that continuous low doses of clonidine in cats reduce the responsiveness of vascular smooth muscles to sympathetic nerve activity, circulating catecholamines, and other vasoactive substances.

A number of clinical studies followed where results from both placebo-controlled and open trials were reported. Sjaasted and Stensrud² reported significant improvement in migraine condition in 13 of the 26 patients who were taking 75 µg of clonidine daily. Healthfield and Raiman³ treated 65 migraine patients with 75 to 150 µg of clonidine daily for 15 months. Initial improvement was reported in 67 percent of the patients, but sustained relief was observed only in 49 percent of the patients.

Shafer, *et al.*⁴ studied 42 patients who experienced 1 to 13 migraine attacks during a 28 day treatment-free, pre-trial period. They reported that clonidine 100 µg administration daily for eight weeks was better than placebo in 57 percent and placebo was better in 33 percent of patients. Significant improvement in the frequency of migraine attacks was observed in 37 patients, who were followed up to one year. Recently, White⁵ reported excellent results in 14 of the 16 patients who were treated with clonidine 50 to 150 µg daily for 2 to 3 months. Munro⁶ found clonidine effective in the prophylaxis of migraine in general practice on four patients previously on other drugs.

Side effects like drowsiness, dryness of the mouth, and anxiety or depression have been reported in various studies. These adverse effects tend to diminish as treatment continues.

From the available data it appears that low-dose clonidine may have a significant effect in reducing the severity and frequency of migraine attacks. Further, well controlled studies would ultimately establish the clinical usefulness vis-a-vis side effects of clonidine in long-term management of migraine.

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- ² Sjaastad O and Stensrud P: 2-(2,6-dichlorophenylamine)-2-imidazoline hydrochloride ST 155 or Catapresan® as a prophylactic remedy against migraine. *Acta Neurol Scand* 47:120, 1971
- ³ Healthfield DWG and Raiman JD: The long-term management of migraine with clonidine. *Practitioner* 208:644 (May) 1972.
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- ⁵ White G: Clinical evaluation of clonidine in the treatment of migraine. *Med Jour Austr* 1:663 (May 24) 1975.
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2. What is the latest information concerning the association between spironolactone and tumor formation?

We previously reported as a "Question and Answer" that a 78-week rat toxicity study conducted by Searle involving high dosages of spironolactone (Aldactone®, also an ingredient in Aldactazide®) disclosed dose-related increases in the incidence of benign tumors of the thyroid and testes. As a consequence, the FDA was to review the relevance to the continued marketing and/or labeling of spironolactone and to take another look at its suggested uses.¹

It was revealed recently in FDC reports² that despite deficiencies rat studies involving chronic spironolactone administration have shown it to be a tumorigen with its proliferative effects manifested on endocrine organs and the liver. They further reported that using 25, 75, and 250 times the usual daily human dose (2 mg/kg) there was a statistically significant dose-related increase in benign adenomas of the thyroid and testes. In female rats there was a statistically significant increase in malignant mammary tumors at the middose only. In male rats there was a dose-related increase in proliferative changes in the liver. At the highest dosage level (500 mg/kg) the range of effects included hepatocytomegaly, hyperplastic nodules, and hepatocellular carcinoma; the last was not statistically significant.²

*This month's column was prepared by J. M. Rosenberg, Pharm. D., H. Kirschenbaum, B.S., and M.K. Raina, M. Pharm., Ph.D., Brooklyn College of Pharmacy, LIU.

Therefore, Searle recently has agreed to a labeling revision which includes the following boxed warning: "Spironolactone has been shown to be a tumorigen in chronic toxicity studies in rats. (See Warnings) Spironolactone should be used only in those conditions described under Indications. Unnecessary use of this drug should be avoided." In addition, they have included a revised warning section detailing the results of animal studies, and restricted indications for use, including a limitation on use in essential hypertension to patients who cannot be treated adequately with other agents or in whom other agents are considered inappropriate.

References

¹ Anon: "G. D. Searle Says Panel is Reviewing Safety of Two Tension Drugs." *Wall Street Journal*, June 5, 1975.

² Anon: FDC Reports — "The Pink Sheet" 38:B-4 (Apr 12) 1976.

3. Compare the recently introduced non-steroidal anti-inflammatory agents related to ibuprofen (Motrin®).

Since the introduction of ibuprofen (Motrin®) in October 1974, three more drugs — naproxen (Naprosyn®), fenoprofen (Nalfon®), and tolmetin (Tolectin®) — have been introduced. (The salient features of these drugs are summarized in the table.)

All of these drugs are related chemically and exhibit anti-inflammatory, analgesic, and antipyretic properties. Three of these — naproxen, fenoprofen, and tolmetin — have been approved only for the relief of signs and symptoms of rheumatoid arthritis, whereas ibuprofen is approved also for use in osteoarthritis. The mode of action of their anti-

inflammatory activity is not fully known; however, involvement of pituitary-adrenal stimulation has been ruled out in all the four drugs. Naproxen, fenoprofen, and tolmetin have been shown to inhibit synthesis of prostaglandins in vitro.¹ Possibly this property may be involved in some manner in their anti-inflammatory activity.

All these drugs are absorbed well orally, have a strong affinity to bind with serum albumin, and are eliminated primarily through the urine. Naproxen and ibuprofen are eliminated largely as unaltered drugs; tolmetin is recovered in urine as an inactive oxidative metabolite and fenoprofen is transformed into two inactive metabolites and excreted in the urine.

Naproxen has a biologic half-life of 13 hours, whereas the serum half-life of the others ranges from 1 to 3 hours. The peak serum levels are obtained from 30 minutes to 4 hours and the therapeutic response is observed after a few days to a week. However, in the case of naproxen, the symptomatic improvement usually begins within two weeks.

In animal studies, some of these agents have shown better anti-inflammatory activity than aspirin,^{2,3} but clinically the response in rheumatoid arthritis was comparable to usual doses of aspirin.^{4,5,6} However, in one controlled double-blind study, tolmetin was shown to be superior to aspirin.⁷

The results of comparative studies with indomethacin (though few) have been variable. While ibuprofen (1200 mg/day) was shown to be as effective as 100 mg of indomethacin,⁸ tolmetin in recommended doses exhibited marginally superior activity than indomethacin.⁹ Naproxen in a daily dosage of 500 mg was equal in effect to 150 mg of indomethacin.¹⁰

Generic Name (Trade Name)	Daily Dosage	Serum Half-Life in Hours	Peak Serum Levels in Hours	Time Lag for Therapeutic Response	Comparison in Rheumatoid Arthritis with aspirin	Rheumatoid Arthritis with indomethacin	Drug Interactions and Adverse Effects	Approximate Daily Dosage Cost*
Ibuprofen (Mortrin)*	300-400 mg t.i.d. or q.i.d.	2	1	Therapeutic response is seen in a few days to a week	Equally effective as usual doses of aspirin ⁴	Equally effective (1200 mg) with 100 mg of indomethacin ⁸	Reports of amblyopia, interference with oral anticoagulants	22c-30c
Naproxen (Naprosyn)*	250 mg b.i.d.	13	2-4	Symptomatic improvement usually begins within 2 weeks	Equally effective as usual doses of aspirin ⁵	500 mg/day have same therapeutic efficacy as 150 mg/day of indomethacin ¹⁰	Possible interaction with warfarin	38c
Fenoprofen (Nalfon)*	600 mg q.i.d.	3	2	Therapeutic response may be apparent in a few days, but in few patients 2-3 weeks may be required to gauge the full benefit	Similar therapeutic effects as aspirin ⁶	Not available	Coadministration of aspirin reduces serum half-life of fenoprofen ¹²	62c
Tolmetin (Tolectin)*	400 mg t.i.d.	1	½-1	Therapeutic response expected in a few days to a week	Clinical response compared to aspirin. However, in one study, tolmetin was shown to be superior to aspirin ⁷	Clinical response comparable to indomethacin. However, in one study tolmetin showed marginal superiority ⁹	No interaction with warfarin reported to date	71c

*Based on the wholesale price to the pharmacist

Comparative evaluations of these drugs in single trials are lacking; however, Reynolds and Whorewell¹¹ reported a double-blind study comparing the anti-rheumatic activity of naproxen, ibuprofen, and fenoprofen. Naproxen exhibited maximum anti-rheumatic activity followed by fenoprofen and ibuprofen.

Although each one of these agents exhibited gastrointestinal and other side effects, these have been of lesser severity and incidence when compared with aspirin and/or indomethacin. Amblyopia, interaction with warfarin, has been reported with ibuprofen. Though such effects as yet have not been observed with the usage of other agents, it is nevertheless wise to exercise caution until more information is available. Concomitant administration of aspirin did not affect the blood levels of ibuprofen,¹ but did decrease the half-life of fenoprofen¹² and increased the rate of excretion of naproxen.¹ However, we have found no data to date on the effects of aspirin on tolmetin.

From the available clinical experience, it appears that these drugs have comparable therapeutic efficacy in rheumatoid arthritis to aspirin and/or indomethacin. The advantage appears to be the lower incidence and severity of gastrointestinal side reactions associated with their use.

References

¹ Package inserts of Motrin,[®] Nalfon,[®] Naprosyn,[®] and Tolectin.[®]

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³ Moxley TE, *et al*: Ibuprofen vs. buffered phenylbutazone in the treatment of osteoarthritis: Double-blind trial. *Jour Amer Geriatr Soc* 23:343 (Aug) 1975.

⁴ Dorman J and Reynolds WJ: Comparison of ibuprofen and acetylsalicylic acid in treatment of rheumatoid arthritis. *Can Med Assoc J* 110:1370 1974.

⁵ Bowers DE, *et al*: Naproxen in rheumatoid arthritis — A controlled trial. *Ann Intern Med* 83:470 (Oct) 1975.

⁶ Anderson IF: Trial of a new anti-rheumatic agent. *So Afr Med J* 48:899 (May) 1974.

⁷ Schneyer JJ: Excerpta Medica International Congress Series No. 372, pp. 48-60. Paper presented at the Tolmetin Symposium, Washington, D.C., April, 1975.

⁸ Cosh JA: Anti-inflammatory drugs in rheumatic diseases. *Practitioner* 213:519 1974.

⁹ Caldwell J, *et al*: Excerpta Medica International Congress Series No. 372, pp. 71-84. Paper presented at the Tolmetin Symposium, Washington, D. C., April, 1975.

¹⁰ Kogstad O: A double-blind crossover study of naproxen and indomethacin in patients with rheumatoid arthritis. *Scand J Rheumatology (Suppl. 2)*: 159, 1973.

¹¹ Reynolds PMG and Whorwell PJ: A single-blind comparison of fenoprofen, ibuprofen, and naproxen in rheumatoid arthritis. *Curr Med Res Opin* 2:461, 1974.

¹² Rubin A, *et al*: A profile of the physiological disposition and gastrointestinal effects of fenoprofen in man. *Curr Med Res Opin* 2:529, 1974.

1976-1977

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1976-1977

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Howard D. Slobodien, M.D. Perth Amboy

Crippled Children Commission, State

- (Appointed by Governor for 5-year term)
Harry W. Fullerton, Jr., M.D. Carney's Point

Death, Committee on Definition of

- (Established by the Board 11/16/75)
Edward F. Murray, M.D., *Chairman* West Orange
Robert E. Green, M.D. Maplewood

Elmer L. Grimes, M.D. Haddonfield
 Harlan M. Mellk, M.D. Livingston
 Irvin Sussman, M.D. Bridgeton

Delaware Valley Regional Medical Program

(Established at invitation of University City Science
 Center — 12/65)

Sherman Garrison, M.D. Bridgeton

Disputed Claims, Advisory Committee to Review MSP and HSP

(Established at request of MSP — 8/21/60 — Quorum: 4
 members)

1st District —
 Ralph M. L. Buchanan, M.D.,
Chairman Phillipsburg
 Charles I. Nadel, M.D. Irvington
 2nd District —
 John J. Bedrick, M.D. Bayonne
 Robert A. Cosgrove, M.D. Jersey City
 3rd District —
 John S. VanMater, M.D. New Brunswick
 John A. Kinczel, M.D. Trenton
 4th District —
 John C. Clark, M.D. Asbury Park
 Frank J. Hughes, M.D. Gloucester
 5th District —
 Don B. Weems, Jr., M.D. Wenonah
 Nicholas E. Marchione, M.D. Vineland

Education, State Department of

(Liaison requested by the Assistant Commissioner of
 Education — 9/21/58)

Glenn P. Lambert, M.D., *Chairman, Special
 Committee on Child Health* Flemington

Electrical Safety and Maintenance Program, Board of Advisors to the

(MSNJ representation requested by New Jersey
 Hospital Association — 12/1/72)

MSNJ's representative will work with the Association of
 Hospital Engineers to develop a safety code for New Jersey
 hospitals.

Bernard M. Schnur, M.D. Trenton

**Emotionally Disturbed Child, Advisory Council to
 Department of Education**

(Liaison requested by Department of Education —
 10/28/68)

William J. Farley, M.D. Brielle

Epilepsy, Advisory Panel to State Director of Motor Vehicles

(Established at request of Director of Motor Vehicles
 — 7/29/66)

J. Berkeley Gordon, M.D. Rumson
 Matthew Menken, M.D. New Brunswick

Executive Committee

(Provided in the Bylaws, Chapter VI, Section 5(b))

John S. Madara, M.D., *President*
(Chairman) Salem
 Frank R. Begen, M.D.,
President-Elect Teaneck
 Charles S. Krueger, M.D.,
First Vice-President Mount Holly
 Alfred A. Alessi, M.D.,
Second Vice-President Hackensack
 James S. Todd, M.D., *Chairman of the
 Board of Trustees* Ridgewood

Graduate Education, Task Force on

(Representation requested by CMDNJ)

James A. Rogers, M.D. Paterson

Health Careers Service, New Jersey

(Physician representation established by Board of
 Trustees 7/20/69)

Karl T. Franzoni, M.D. Trenton

Health Care Administration Board

MSNJ Executive Committee members and Trustees
 (on an alphabetical, rotating basis) notified of meeting
 dates.

(Per Board action 2/15/76)

Health Careers Service, Resource Persons to New Jersey

(Liaison established at request of Health Careers
 Service — 7/19/64)

Presidents of Component Societies

Health Institutional Long Range Plans,

Advisory Committee for Minimum Requirements for

(Representation requested by the Department of Health
 10/11/74)

Matthew S. Boylan, M.D. Avon-by-the-Sea

Health Insurance Conference

(Committee established at request of Health Insurance
 Council — 3/24/57)

Arthur Bernstein, M.D., *Secretary*
(Chairman) Maplewood
 John S. Madara, M.D., *President* Salem
 Frank R. Begen, M.D., *President-Elect* Teaneck
 Charles S. Krueger, M.D., *First
 Vice President* Mount Holly
 Alfred A. Alessi, M.D., *Second
 Vice-President* Hackensack
 Mr. Vincent A. Maressa, *Executive Director* Trenton

Health Professions Education Advisory Council

(Department of Higher Education)

William J. D'Elia, M.D. (1977) Spring Lake
 John J. Crosby, M.D. (1978) Jersey City

Historian-Archivist

(Created at the suggestion of the Executive Director —
 1/13/57)

Morris H. Saffron, M.D. (Appointed 5/67) Passaic

Home Health Agencies, State Committee to

Develop Standards for Licensure of

(MSNJ representation requested by the Secretary of the
 Licensure Committee of the New Jersey Department of
 Health — 10/15/72)

David Eckstein, M.D. Trenton

Hospital Association, New Jersey

(Liaison established at request of New Jersey Hospital
 Association — 12/17/67)

Rudolph C. Gering, M.D. Trenton

Hospital Advisory Council, State Department of Health

(Appointed by the Commissioner of Health for an
 indefinite term)

Nicholas E. Marchione, M.D. Vineland

**House Maintenance, Staff Policies and
Personnel Relations**

(Special Committee created by Board of Trustees —
9/21/58)

John S. Madara, M.D., *President*
(*Chairman*) Salem
Frank R. Begen, M.D., *President-Elect* Teaneck
Arthur Bernstein, M.D., *Secretary* Maplewood
Rudolph C. Gering, M.D., *Treasurer* Trenton
James S. Todd, M.D., *Chairman*,
Board of Trustees Ridgewood
I. Edward Orna, M.D., *Chairman*,
Committee on Finance and Budget Cherry Hill
Mr. Vincent A. Maressa, *Executive Director* ... Trenton

Industrial Safety Board, New Jersey

(Appointed by the Governor — 8/71)

Delma W. Caldwell, M.D. Linden

JEMPAC, Conference Committee with

(Established at request of JEMPAC — 6/25/67)

Meyer L. Abrams, M.D., *Chairman*
Council on Legislation Willingboro
Victor H. Boogdanian, M.D., *Chairman*
Council on Medical Services New Brunswick
Alfred A. Alessi, M.D., *Second*
Vice-President Hackensack

**Judiciary and Bar, Conference Committee on
Inter-Relations with the**

(Established at invitation of Supreme Court — 11/17/63)

John S. Madara, M.D., *President* Salem
Frank R. Begen, M.D., *President-Elect* Teaneck
Charles S. Krueger, M.D., *First*
Vice-President Mount Holly
Alfred A. Alessi, M.D.,
Second Vice-President Hackensack
James S. Todd, M.D., *Chairman*
Board of Trustees Ridgewood
Arthur Bernstein, M.D., *Secretary* Maplewood
Rudolph C. Gering, M.D., *Treasurer* Trenton
Meyer L. Abrams, M.D., *Chairman*
Council on Legislation Willingboro
Paul J. Kreutz, M.D., *Chairman*
Committee on Medical Defense and Insurance Elizabeth
William J. D'Elia, M.D. Spring Lake
James A. Rogers, M.D. Paterson
Emanuel M. Satulsky, M.D. Elizabeth
Samuel J. Lloyd, M.D. Trenton
Nicholas E. Marchione, M.D. Vineland
Mr. Vincent A. Maressa, *Executive Director* ... Trenton
Mr. Joseph C. Lucci, *Executive Assistant* Trenton
Equal representation from:
Supreme Court Committee on Relations with the
Medical Profession

Legislation

(To be considered at a later date — Board action 6/3/75)

- (1) Federal Keymen
(Mechanism established by MSNJ — 4/4/54 — to serve
as official intermediaries between MSNJ and the
Federal legislators)
15 Congressional District Keymen
1 Senatorial Keyman
- (2) State Keymen
(Mechanism established by MSNJ — 7/13/52)
Keymen in 15 Legislative Districts/21 Component
Societies

Medicaid, Committee on

(Established by the Board on 9/21/75, at the request of
the Essex County Medicaid Committee)

Medicaid, Negotiating Committee For

(Established by Board of Trustees to work with the State
Medicaid Commission — 12/22/68)

John S. Madara, M.D., *President* Salem
Frank R. Begen, M.D., *President-Elect* Teaneck
Victor H. Boogdanian, M.D., *Chairman*,
Council on Medical Services New Brunswick

Medicaid Peer Review Committee

(Established by Board of Trustees 4/19/70 at the request
of the Department of Institutions and Agencies. The func-
tion of the Committee will be to act upon inquiries and/or
complaints originating either with the administrators of the
Medicaid Program or with physicians serving under the
program.)

1st District —
Nicholas A. Bertha, M.D. Wharton
2nd District —
Ambrose P. Boyle, Jr., M.D. Fort Lee
3rd District —
Rudolph C. Gering, M.D. Trenton
4th District —
Emanuel Abraham, M.D. Asbury Park
5th District —
Jesse Carll, IV, M.D. Bridgeton

Medicaid Program, Medical Advisory Committee to the

(Appointment of four representatives requested by
Department of Institutions and Agencies — 6/12/69)
Donald P. Burt, M.D. Morristown
Arthur C. Dietrick, M.D. Mount Holly
John D. Franzoni, M.D. Trenton
Leo J. Kelly, Jr., M.D. South Orange

Medical Assistance Advisory Council

(Established at invitation of State Medicaid Commission
— Board action 4/20/69)

A. Guy Campo, M.D. Westville
Anthony P. DeSpirito, M.D. Asbury Park

**Medical Assistants, (State of New Jersey)
American Association of**

(Liaison requested by Association — 9/15/63)

William J. D'Elia, M.D. Spring Lake

Medical Directorship for MSNJ, Committee to Study o

(Established by Board action 4/25/76)

James A. Rogers, M.D., *Chairman* Paterson
David R. Brewer, Jr., M.D. Mullica Hill
David Eckstein, M.D. Trenton
Charles S. Krueger, M.D. Mount Holly
Henry J. Mineur, M.D. Cranford

Medical Education of New Jersey, Office of Continuing

(Liaison requested by College of Medicine and
Dentistry of New Jersey — 4/20/72)

John F. Kustrup, M.D. Trenton
Arthur Bernstein, M.D. (alternate) Maplewood

Medical-Hospital-Nursing Conference (Tri-Portite)

(Liaison established by MSNJ — 1/13/57)

John S. Madara, M.D., *President* Salem

Frank R. Begen, M.D., *President-Elect* Teaneck
 James A. Rogers, M.D., *Immediate*
Past President Paterson
 Mr. Vincent A. Maressa, *Executive Director* ... Trenton
 Equal representation from:
 New Jersey Hospital Association
 New Jersey State Nurses' Association

Medical Liaison Committee

(High-level conference groups for discussion and consideration of items of mutual interest)

John S. Madara, M.D., *President* Salem
 Frank R. Begen, M.D., *President-Elect* Teaneck
 James A. Rogers, M.D., *Immediate*

Past-President Paterson
 Mr. Vincent A. Maressa, *Executive Director* ... Trenton
 (Where number of representatives from other organization is larger than number of MSNJ representatives, the latter will be increased from the Presidential Officers to equal the former.)

- (1) Medical-Dental
 (Liaison requested by the Dental Society — 6/10/51)
- (2) Medical-Hospital
 (Liaison established by MSNJ — 10/25/53)
- (3) Medical-Legal
 (Liaison established by MSNJ — 10/25/53)
- (4) Medical-Nursing
 (Liaison established by MSNJ — 4/4/54)
- (5) Medical-Osteopathic
 (Liaison requested by Osteopathic Association — 9/17/61)
- (6) Medical-Pharmaceutical
 (Liaison established by MSNJ — 7/26/53)

Medical-Surgical Plan Board of Trustees

(Provided in MSP Bylaws)

John S. Madara, M.D., *President* Salem

Medicare Peer Review Committee

(Established by Board of Trustees 12/20/70 at request of fiscal intermediary. Committee will review and evaluate claims involving questions of over-utilization under Medicare. Composition of committee includes six groups of three members each in the fields of general practice, general surgery, orthopedic surgery, internal medicine, ophthalmology, and urology.)

Membership Directory

(Special committee established by Board — 11/19/61)
 Arthur Bernstein, M.D., *Chairman* Maplewood
 Matthew E. Boylan, M.D. Avon-by-the-Sea
 William Greifinger, M.D. Belleville
 Daniel B. Roth, M.D. Teaneck
 Mr. Vincent A. Maressa, *Executive Director* ... Trenton
 Mr. Robert H. Lambert, *Bs. and Fin. Mgr.* Trenton

Membership Inquiry and Complaint Mechanism

(Established at the 12/10/72 Special Session of the House of Delegates to deal more effectively with third party insurance carriers and government medical programs as they affect the practices of the membership.)

Membership Inquiry and Complaint Committee with Medical-Surgical Plan of New Jersey

Samuel Baum, M.D. Passaic
 Donald P. Burt, M.D. Morristown
 Arthur C. Dietrick, M.D. Mount Holly

Karl T. Franzoni, M.D. Trenton
 James E. George, M.D. Westville

Membership Inquiry and Complaint Committee with Medicare

Alfred A. Alessi, M.D. Hackensack
 William H. Coleman, M.D. Trenton
 Richard H. DuPree, M.D. Woodbury
 Andrew G. Hudacek, M.D. Morristown
 Joseph W. Schauer, Jr., M.D. Farmingdale

Membership Inquiry and Complaint Committee with Medicaid

John J. Crosby, Jr., M.D. Jersey City
 Michael J. Doyle, M.D. Neptune
 Armando F. Goracci, M.D. Woodbury
 Frederick J. Knocke, M.D. Readington
 Robert E. McNamara, M.D. Newark

Membership Inquiry and Complaint Committee with Other Carriers

Melvin J. Andrews, M.D. Cherry Hill
 Emanuel M. Satulsky, M.D. Elizabeth
 Howard D. Slobodien, M.D. Perth Amboy
 Robert A. Weinstein, M.D. Newton
 Carl Minitti, M.D. Gibbstown

New Jersey College of Medicine and Dentistry, Student AMA

(Liaison requested by New Jersey Chapter — 1/26/60)
 Edward A. Wolfson, M.D. Glen Rock

New Jersey Health Sciences Group

(Membership requested by the Group 1/19/75)
 Edward G. Bourns, M.D. Jamesburg

New Jersey Health Sciences Group Legislative Affairs Committee

(Liaison requested by the Group 11/16/75)
 Meyer L. Abrams, M.D. Willingboro

Nurse Pediatrician or Pediatric Nurse, Advisory Council on the

(Liaison established by the Board of Trustees — 2/27/72 — at the request of Rutgers University)
 Harold L. Colburn, Jr., M.D. Moorestown

Nurses' Association, Joint Practice Committee with the New Jersey State

(Established by Board of Trustees — 7/16/72 — to clarify roles and functions of nursing and medicine within the health care delivery context, with the objective being the improvement of health care delivery services.)
 William J. D'Elia, M.D., *Chairman* Spring Lake
 Robert P. Hershkowitz, M.D. Long Branch
 James A. Rogers, M.D. Paterson
 Mr. Vincent A. Maressa, *Executive Director* ... Trenton
 MSNJ's Executive Committee

Nursing Facilities, Advisory Committee on Skilled

(MSNJ representation requested by Assistant Commissioner for Health Facilities, New Jersey Department of Health — 4/30/73. The Committee will revise standards for licensure of skilled nursing facilities.)
 David Eckstein, M.D. Trenton

Nutrition Council, New Jersey

(Liaison established by MSNJ — 12/19/54)
 Howard Jacobson, M.D. Piscataway

**Ochompus (Office for Civilian Health and Medical
Program of the Uniformed Services)**

- (1) Fiscal Agent
(Designated upon request of MSP — 7/21/63)
Medical-Surgical Plan of New Jersey
- (2) Special Committee on
(Established by MSNJ — 9/9/56)
David Eckstein, M.D., *Chairman*Trenton
George L. Benz, M.D.Newark
I. Edward Ornaf, M.D. Cherry Hill

Osteopaths, Special Committee To Study Admission of

- (Established at the direction of the House by the President
6/8/76)
Sherman Garrison, M.D., *Chairman* Bridgeton
Francis X. Keeley, M.D. Haddonfield
Charles S. Krueger, M.D. Mount Holly
Howard Lehr, M.D. Fanwood
Stephen Levine, M.D. Cherry Hill

Parents and Teachers, New Jersey Congress of

- (Liaison requested by MSNJ's Committee on Child
Health — 12/20/64)
William J. Farley, M.D. Brielle

Pension Plan, Special Committee on

- (Established by Board — 5/22/55 ... Duties outlined in
Article III of Pension Plan Agreement)
I. Edward Ornaf, M.D., *Chairman, Committee on
Finance and Budget* Cherry Hill
John S. Madara, M.D., *Chairman, Special Committee
on House Maintenance, Staff Policies, and Personnel
Relations* Salem
Rudolph C. Gering, M.D., *Treasurer*Trenton

Professional Liability, Joint Ad Hoc Committee on

- (Established by the Board 7/20/75)
James S. Todd, M.D., *Chairman*
(*Chairman, Board of Trustees*) Ridgewood
Meyer L. Abrams, M.D., (*Chairman,
Council on Legislation*) Willingboro
John T. Franzoni, M.D., (*Vice-Chairman,
Council on Legislation*)Trenton
Two members-at-large from Council on Legislation:
John J. Crosby, Jr., M.D. Jersey City
John R. Tobey, M.D.Newark
Paul J. Kreutz, M.D., (*Chairman, Committee on
Medical Defense and Insurance*)Elizabeth
Alfred A. Alessi, M.D., (*Vice-Chairman, Committee on
Medical Defense and Insurance*) Hackensack
Two members-at-large from Committee on Medical
Defense and Insurance:
Irving P. Borsher, M.D.Newark
William J. D'Elia, M.D.Spring Lake
David R. Brewer, Jr., M.D., *Consultant* ...Mullica Hill
Representatives of Specialty Societies invited to all meetings

Quackery, Committee on

- (Established at the request of the AMA — 11/15/64)
James S. Todd, M.D., *Chairman* Ridgewood
Richard B. Berlin, M.D. Englewood
Charles B. Norton, M.D. Woodstown

Radiation Protection Commission, Consultant to New Jersey

- (Nomination for appointment to Commission requested
— 7/18/65)
Bernard M. Schnur, M.D.Trenton

Radiation Protection Commission, New Jersey

- (Two consultants in nuclear medicine requested by the
Commission 11/66)
Frank R. Schell, M.D.Wayne
John J. Thompson, M.D. Caldwell

Regional Planning Council, Philadelphia Medical Library

- (Appointment of representative requested by Library
Committee — 8/20/67)
Sherman Garrison, M.D. Bridgeton

Rehabilitation Services, Division of Vocational

- (Liaison requested by MSNJ's Committee on
Rehabilitation — 5/65)
Daniel J. O'Regan, M.D. Jersey City

Resolutions, Committee on Annual Meeting

- (Established by Board of Trustees — 7/18/71 — to re-
view all resolutions in advance of the annual meeting)
James A. Rogers, M.D., *Chairman* Paterson
Matthew E. Boylan, M.D. Avon-by-the-Sea
William J. D'Elia, M.D.Spring Lake

Safety Council, New Jersey State

- (Provided in Council bylaws)
John S. Madara, M.D., *President* Salem
Delma W. Caldwell, M.D., *President's
Representative*Linden

Selective Service System, New Jersey Chairman of Advisory Committee

- (Nomination for appointment by National Advisory
Committee requested by committee — 11/19/61)
Charles L. Cuniff, M.D. Jersey City

State Board of Medical Examiners

- Trustees notified of meeting dates on an alphabetical,
rotating basis. (Per Board action 12/15/74)

**Thyroid Glands, Ad Hoc Committee To Study the Management of
Persons with Previously Irradiated**

- (Established at the request of the Radiological Society
of New Jersey)
David Eckstein, M.D., *Chairman*Trenton
Alexander Crosett, M.D.Summit
Elmer Grimes, M.D. Haddonfield
Henry Kuperman, M.D.Irvington
Philip J. G. Quigley, M.D.Elizabeth

Welfare Council, New Jersey

- (Representative to plan meetings for annual conference on
social welfare requested by Council — 5/13/66)
John J. Bedrick, M.D. Bayonne

Widows and Orphans of Medical Men of New Jersey

- (Liaison requested by Society — 5/17/59)
Joseph R. Jehl, M.D.Clifton

CLINICAL NOTES

Fournier's Disease

R. R. Tutela, M.D., L. Reddy, M.D., and S. R. LoVerme, M.D./Newark*

In 1883 Fournier, of Paris, described a clinical entity consisting of gangrene of the scrotum and surrounding areas. Since then, others have also described this uncommon condition, giving it different names, such as essential gangrene, fulminating gangrene, idiopathic gangrene, and streptococcal gangrene. Approximately 300 cases have been reported in the literature since that time. The cardinal features of this disease are:

- (1) Essential gangrene involving the scrotum and surrounding tissues. This gangrene may also extend to distant regions of the body.
- (2) Sudden onset
- (3) Rapid progress with development of chills, fever, and signs of toxemia within 48 hours.
- (4) Multiple organisms are usually found.
- (5) Associated with a high mortality — 30 percent in the pre-antibiotic era.



Figure 1 — After incision and draining with testicles exposed.

(6) Idiopathic etiology — although in about 40 percent of the cases there have been associated conditions such as chancroid, balanitis, minor trauma and retrocecal appendicitis.

Case Report

A 29-year-old male was seen in the emergency room because of vomiting and disorientation of 6 to 12 hours duration. He was a known alcoholic and had been drinking heavily for a few days preceding admission. He was ill-nourished, dehydrated, and had poor general hygiene. His blood pressure was 80/0, temperature 102°, and pulse 102. A diffuse tender swelling was noted over the perineum, penis, and scrotum, with extension to the right inguinal area and flank.

Multiple incisions were made in the right flank, right groin, scrotum, sacrum and the right and left ischial areas. A thick,



Figure 2A — Gangrene and infection of genitalia and groin, secondary to Fournier's Disease, replaced by clean and healthy granulation tissue. Note area of incision and drainage of right groin.

*From the Department of Plastic and Reconstructive Surgery, CMDNJ, Martland Hospital Unit, Newark where Dr. Tutela is Chief Resident, Dr. Reddy is Clinical Assistant Professor and Dr. LoVerme is Clinical Professor, New Jersey Medical School, CMDNJ. This item was presented at the annual meeting of the New Jersey Society of Plastic and Reconstructive Surgery, March 6, 1975.

grayish, malodorous pus exuded. The laboratory reported gram positive cocci,^a gram negative diplococci,^a and bacterioides fragilis. All areas developed healthy granulation tissue and on the 25th day split thickness skin grafts were applied to the scrotum and penis. A rotation flap was necessary to close the sacral area. (Figures 1, 2A, 2B)



Figure 2B — Split thickness skin grafts have been applied to genitalia.

Discussion

Considering the explosive and fulminating course of this disease it should be treated immediately and aggressively. Treatment of shock, along with antibiotics^b and incision and drainage of abscesses are essential. Wound closure must be accomplished later.

In the differential diagnosis one should consider torsion of the testes, strangulated scrotal hernia, orchitis, urinary extravasation, periurethral abscess, and synergistic gangrene.

Summary

A case report of Fournier's Disease is presented. The cardinal features, differential diagnosis, and recommendations for treatment of the disease are outlined.

References

1. Buchanan DJ: Idiopathic scrotal gangrene. *Brit Med J* 4:672-3, Dec. 1972.
2. Burpee JF and Edwards P: Fournier's gangrene. *J Urol* 107: 812-4, May 1972.
3. Fournier JA: Cited by Gibson In: Gangrene foudroyante de la verge. *Sem Med (Paris)* 3:345, 1883.
4. Fournier JA: Cited by Gibson In: Etude clinique de la gangrene foudroyante de la verge. *Sem Med (Paris)* 4:69, 1884.
5. Frier BM and Howie AD: Scrotal gangrene in asymptomatic myeloma *Brit Med J* 426, Oct. 1972.
6. Nicholas JL: Fournier's gangrene in a boy aged seven years. *Brit J Clin Pract* 26:86-7, Feb. 1972.
7. Pryon JP, Yates-Bell AJ, and Packham DA: Scrotal gangrene after male sterilization. *Brit Med J* 1:272, Jan. 1971.
8. Randall A: Idiopathic gangrene of the scrotum. *J Urol* 4:219, 1920.
9. Singh A and Singh S: Fournier's gangrene of the scrotum. *J Indian Med Assoc* 56:137-8, Mar. 1971.
10. Talarico RD: Fournier's gangrene. *Mod Treat* 7:1049-53, Sept. 1970.

Urethral Suppositories* To Induce Urination

Pasquale E. Nappi, M.D. and
Gustav L. Ibranyi, M.D., Newark

In the only instance in which we failed to correct stress incontinence (because of a broken silk suture), we used urethral suppositories to induce urination. The suppositories did not have to be used again as the patients had no difficulty in urination afterwards. Urethral suppositories prevent asymptomatic pyuria and have been used successfully to induce urination in 76 patients.

^aFinal report showed organisms to be peptostreptocci and veillonella species.

^bIn this case the antibiotics used were penicillin, clindamycin, and gentamicin.

*Furacin Suppositories®, Eaton Laboratories

LETTERS TO THE JOURNAL

Second Surgical Opinion

May 26, 1976

Dear Sir:

Since Dr. Eugene G. McCarthy published his study (in December 1974) of screening elective surgery in two New York unions, many critiques have been published, yet many screening programs have sprung up. We have followed all developments and reviewed Dr. McCarthy's latest report presented in Atlantic City on May 2, 1976.

Projects involving a second surgical opinion have started in Michigan, Pennsylvania, New York, Massachusetts, and New Hampshire-Vermont. Group Health Insurance of New York (GHI) has indicated interest in extending its voluntary project to include New Jersey panelists, and New Jersey Insurance Commissioner James J. Sheeran is evidencing an interest in a program for local carriers. Consultant screening is now mandatory for elective surgery under the New York Medicaid program, and Blue Shield of New York now has a functioning voluntary project.

In the event that panels are established in New Jersey for the screening by consultants on recommended elective surgical procedures, and in order to assist in establishing a proper level of qualification for consultants, the New Jersey Chapter of the American College of Surgeons recommends that all panelists chosen be board certified and/or Fellows of the American College of Surgeons.

(signed) Adolph R. Wichman, M.D.

**1977 Annual Meeting
May 14-17**

Tribute to a Distinguished Neurosurgeon

May 28, 1976

Dear Dr. Krosnick:

Dr. E. Jefferson Browder, who died on May 1, 1976, was a distinguished neurosurgeon and clinical professor on the staff of the New Jersey College of Medicine and Dentistry at Newark. He lived at Hackettstown, New Jersey and had many friends among the physicians of New Jersey.

Dr. Browder spent most of his active neurosurgical years in Brooklyn, New York, in private practice and as head of the Department of Neurosurgery at the Downstate Medical Center in Brooklyn, retiring at the age of sixty-five years as emeritus professor. His work on the surgical treatment of the Parkinson patient as well as his studies on head trauma received world-wide recognition.

Dr. Browder, among many other honors, was President of the Association for Research in Nervous and Mental Diseases, Vice-President of the American Neurological Association, President of the American Board of Neurosurgery, and a Governor of the American College of Surgeons from 1952 to 1955.

He contributed over 100 publications to scientific journals. Of interest, however, is that after the age of 80 years, as a staff member of the East Orange VA Hospital and as professor of neurosurgery at the College of Medicine and Dentistry of New Jersey at Newark, he was still writing and publishing medical papers. His last work, of which he is the principal author, is a monograph on original work on the dural sinuses performed over the last three years and is being published posthumously.

His trainees, now performing neurosurgery in various regions of the United States, have formed the Browder Neurosurgical Society and meet annually in scientific sessions.

I believe that Dr. Browder should be considered as one of the favorite sons of New Jersey and will be sadly missed by his many friends.

(Signed) Harry A. Kaplan, M.D.

Sharing Our Ideas

June 22, 1976

Dear Doctor Krosnick:

May I congratulate you on your two blunt and hard-hitting editorials, "Place the Shoe Where It Fits" and "What is Necessary?" (*JMSNJ* 73: 480-482).

The problem, of course, is to spread the word outside the profession, and I hope that copies of your editorials have been sent to as many concerned parties as possible.

Keep up the great work!

(signed) Robert A. Goldstone, M.D.

July 1, 1976

Dear Dr. Krosnick:

It was not nice of you to put me on the spot, with respect to my suggestions concerning distribution of your editorials. It is much easier to complain than to be specific.

I wrote to you because you addressed yourself so eloquently to the paradoxes we face, where the same people who demand quality and increased service on the one hand insist upon reckless cost cutting and impose uninformed bureaucratic controls on the other hand.

Perhaps these thoughts could be composed to be submitted to the "Op Ed" page of *The New York Times*. They should be circulated to the editorial writers of our New Jersey papers as source material, with the hope that they might see the problem through our eyes, and possibly be moved to editorialize on our behalf.

Such mechanism should exist for bringing these editorials which concern real problems of concern to the state, to the attention of appropriate state officials, from the governor through the various commissioners and administrators involved. The list at this time should include such names as Byrne, Klein, Reilly, Sheeran, and so on. Members of the legislature should also receive this material.

When a special committee of the Medical Society exists, such as the "Ad Hoc Committee on Medicaid," a mechanism should exist so that they might be alerted when an editorial in their sphere of activity appears, and sufficient reprints provided so that they might use the material.

As long as we confine our complaints to *The Journal* we are talking only to ourselves. We are all convinced. The public is being deceived and shabbily treated by its elected representatives, and we must bring this to their attention. The legislators act frequently out of ignorance, because we are a "silent minority" and also because they just don't understand the art and science of medicine.

I hope that these few comments begin to answer the question you asked me. Perhaps we could throw this open to the readers of our *Journal*. The pages of *The Journal* could be our forum.

(signed) Robert A. Goldstone, M.D.

Lead Toxicity and Renal Function

July 1, 1976

Dear Dr. Krosnick:

The announcement of the New Jersey State Department of Health's concern for lead workers (Occupational Lead Poisoning. *J Med Soc NJ* 73:541, 1976) represents welcome recognition of the inadequacy of blood lead determinations for detecting lead toxicity (see Vitale LF, Joselow MM, Wedeen RP, and Pawlow M: Blood lead — An inadequate measure of occupational exposure. *J Occup Med* 17:155, 1975). The practice of lowering blood lead levels by brief chelation therapy to comply with Federal standards omits evaluation of body lead burdens and specific organ damage. The risks of chelating agents are thus commonly compounded by ignoring potentially dangerous body stores of lead despite "acceptable" blood lead levels.

Your readers may be interested to know that studies performed at the Jersey City Medical

Center over the last few years have identified the only documented cases of occupational lead nephropathy in the United States (Wedeen RP, Maesaka JK, Weiner B, Lipat GA, Lyons MM, Vitale LF, and Joselow MM: Occupational lead nephropathy. *Am J Med* 59:630, 1975). This work, performed in cooperation with the New Jersey Medical School at Newark, has been undertaken without Federal research support. To date, we have found 17 cases of reduced renal function among 41 lead workers with excessive body lead burdens examined. At the time of the study, only one of these workers had "abnormal" blood lead according to current NIOSH guidelines (greater than 80 micrograms per 100 ml). In only three of the 17 were blood lead levels in excess of the proposed 60 micrograms per 100 ml standard at the time of evaluation.

When lead nephropathy progresses to end-stage renal disease, it is impossible to determine the etiology of the renal failure. When uremia supervenes, the cost to the nation for chronic hemodialysis is enormous. Wouldn't HEWs concern about lead workers be more compelling if they provided resources at the investigative level to identify this preventable form of renal disease?

(signed) Richard P. Wedeen, M.D.

Dr. Dock's Green Pastures

July 6, 1975

Dear Editor:

Dr. Strober (*JMSNJ*, June 1976, p. 552) was careless in his description of the Lutheran Medical Center in Brooklyn. That Center now consists of an immaculately maintained 350-bed hospital, one of the largest family practice clinics in the country, and a large outpatient clinic. A new Center, which will combine these clinics and a 550-bed hospital, is nearly completed, and will be functioning early in 1977.

I left the Manhattan V.A. in April 1975 because the Center had better equipment for study of

cardiac patients than the Manhattan V.A. Clinic.

Dr. Strober implied that I "apparently had been retired by the Medical School (S.U.N.Y., Downstate) and the Veterans Administration." Downstate and other S.U.N.Y. medical schools have a retirement age of 70. This may be proper for biochemists and physiologists, but I believe 62 to 65 is better for clinicians or pathologists. So I resigned at 65 to work with the V.A. which has no retirement age and some invaluable physicians over 80.

As one ages, one needs green pastures. The presently overcrowded Lutheran Medical Center is growing and full of life — just what I needed so I could wear out, not rust away.

(signed) William Dock, M.D.

Atlantic City Preferred

Those delegates who attended the meetings of the House during the 210th Annual Meeting in June were polled as to their preference for the location of the 1977 convention. The following is a result of that poll. (Of the "other" sites, one—Bermuda cruise—received 26 votes; the remaining 27 votes were scattered among 11 locations.)

County	Atlantic City	Cherry Hill	Other	No preference
Atlantic	7	—	—	—
Bergen	20	10	7	2
Burlington	4	6	2	—
Camden	15	9	—	2
Cape May	1	—	1	—
Cumberland	3	—	—	—
Essex	31	14	10	4
Gloucester	3	2	—	1
Hudson	22	3	1	—
Hunterdon	1	1	—	—
Mercer	13	7	2	1
Middlesex	7	4	7	1
Monmouth	8	9	3	2
Morris	10	4	6	—
Ocean	3	—	6	—
Passaic	12	9	4	3
Salem	2	2	—	—
Somerset	5	—	1	—
Sussex	3	—	—	—
Union	—	11	3	7
Warren	2	—	—	—
Fellows/Officers	2	—	—	—
Totals	186	91	53	23

ANNOUNCEMENTS

Course in Pediatric Clinical and Theoretical Allergy

In cooperation with the New Jersey Medical School, CMDNJ, the Children's Hospital of Newark is sponsoring a review course in clinical problems in pediatric allergy designed for pediatricians, family physicians, and allergists. The program runs from September through May. Lectures are held each Thursday from 11 a.m. to 12 noon in the Chapel Conference Room at United Hospitals of Newark. In addition a pediatric allergy clinic will be held from 8:30 to 10 a.m. on each of these days, and from 12 noon to 1 p.m. there will be a pediatric conference. Hour-for-hour credit will be awarded in Category I of the AMA Physician's Recognition Award. Tuition is \$100. For information, please address a communication to Arthur F. Fost, M.D., Director of Allergy, Children's Hospital of Newark, 15 South 9th Street, Newark 07107.

The schedule for September and October is as follows:

Sept. 16 — History of Allergy and Scope of the Problem
Sept. 23 — Pediatric Pulmonary Conference
Sept. 30 — Basic Concepts in Immunology

Oct. 7 — Anaphylactic or Type I Reactions
Oct. 14 — Mediators of the Allergic Reactions
Oct. 21 — Immunodeficiency Disorders
Oct. 28 — Pediatric Pulmonary Conference

Symposium on Pediatric Critical Care

On September 18 and 19, the Jersey Shore Medical Center is sponsoring a symposium on pediatric critical care. The sessions are held at the Center from 9 a.m. to 12 noon on the first day and from 10 a.m. to 2 p.m. on the 19th. Subjects to be covered on Saturday are croup and epiglottitis, nursing intervention in airway obstruction, and techniques and complications in artificial airways. Luncheon will follow. On Sunday topics include intracranial pressure in near drowning, nursing intervention in intracranial pressure, measuring and treating increased intracranial pressure, and the role of

physicians, nurses, and parents in terminal increased intracranial pressure. Additional information is available from Anthony P. DeSpirito, M.D., Coordinator, Department of Pediatrics, Jersey Shore Medical Center, Neptune 07753.

Conference on Primary Care

From September 30 to October 2, the School of Health Services of Johns Hopkins University will present a two-and-a-half day conference on the diagnosis and management of primary care problems. The program is designed for physician and non-physician practitioners. There will be lectures and seminars on adult, pediatric, gynecologic, and general health care topics. Approval has been given for 17 credit hours in Category I of the AMA Physician's Recognition Award and by the American Academy of Physicians' Assistants. The fee for physicians is \$110; for non-physicians the cost is \$65. For additional information please write to the Office of Continuing Education, Johns Hopkins Medical Institutions, Room 19, Turner Auditorium, 720 Rutland Avenue, Baltimore, 21205.

Seminar on Cardiopulmonary Equipment

The Delaware-Raritan Lung Association is sponsoring a two-day seminar — September 30 and October 1, Holiday Inn, North Brunswick — entitled "Equipment Seminar II — State of the Art 1976." A commercial equipment display will be presented on the first day. Physicians and therapists are invited to present their own equipment or test modifications. For additional information, please communicate with Ms. Linda D. Hummel, Delaware-Raritan Lung Association, P.O.Box 2006, Princeton 08540.

Review Series in Internal Medicine

On ten successive Wednesdays — October 1 thru December 3 — at the Sheraton Inn—Newark

Airport, Routes 1 and 9 in Elizabeth, the Academy of Medicine and the Department of Medicine of New Jersey Medical School, CMDNJ, is offering review courses in internal medicine. Each program, which it is expected will run about six hours, is geared to an understanding of the basic knowledge of the specialty covered on each day. Topics for review are gastroenterology, cardiology, pulmonary disease, oncology and immunology, rheumatology, infectious diseases, hematology, liver disease, renology, and endocrinology and metabolism. Tuition is \$200 and includes morning collation and luncheon. There will be no partial registration for individual sessions. Sixty credit hours will be awarded in Category I of the AMA Physician's Recognition Award for attendance. For additional information please communicate with the Academy of Medicine, 2424 Morris Avenue, Union 07028 — (201) 687-8780.

Clinical and Histopathological Survey of Gynecology and Obstetrics

From October 4 to 8, at the St. Barnabas Medical Center in Livingston, a survey course in obstetrics and gynecology will be offered. Purpose of the course is to provide the obstetrician and gynecologist, from both a clinical and histopathologic viewpoint, with an in-depth survey of the female genital tract. Each organ system will be reviewed and gross and microscopic materials will be studied and correlated with the clinical picture of various disease entities, including diagnosis and therapy. Approval has been given for 50 cognates by the American College of Obstetricians and Gynecologists and for 40 credit-hours in AMA Category I. Enrollment is on a first-come basis. The fee is \$425 for the week and covers cost of instruction, booklets, and 100 slides with accompanying descriptions. A nonrefundable deposit of \$25 is payable at the time of registration. The balance is payable before October 1. Please request a registration form and send your check to James L. Breen, M.D., Research Fund, Department of Obstetrics and Gynecology, St. Barnabas Medical Center, Livingston 07039. A limited number of rooms have been set aside at the Holiday Inn, Route 10, Livingston, and at

the Turtle Brook Inn, 555 Northfield Avenue, West Orange. Transportation to St. Barnabas will be provided.

Symposium on Expanding Dimensions of Consciousness

The Sixteenth Annual Symposium offered by the Carrier Clinic Foundation will be held on Wednesday, October 6, at the Clinic in Belle Mead. The all-day session (beginning at 9 a.m.) is titled, "Expanding Dimensions of Consciousness" and includes the following topics:

Altered States of Consciousness — C. T. Tart, Ph.D., Professor of Psychology, University of California

Multichannel EEG Synchrony Training — L. G. Fehmi, Ph.D., Princeton

Biofeedback Hypothesis — Patricia Carrington, Ph.D., Department of Psychology, Princeton University

Psychobiology of the Relaxation Response — B. C. Glueck, M.D., Director of Research, Institute of Living, Hartford

The presentations will be followed by a panel discussion. Also offered are workshops on Biofeedback and Meditation, which are open to a limited number of early registrations. Fee, including luncheon, is \$25. For additional information, please communicate with A. Arthur Sugerman, M.D., The Carrier Clinic, Belle Mead, New Jersey 08502.

Regional Chest Conference

On October 7, in the Link Conference Room at Rutgers Medical School, Piscataway, the Central New Jersey Regional Chest Conference will convene at 4 p.m. Sponsored by the Delaware-Raritan Lung Association and the New Jersey Thoracic Society, the session will present as its speaker L. Fred Ayvazian, M.D., Chief of the Pulmonary Disease Section, VA Hospital, East Orange. His topic is "Ectopic Production of Big ACTH in Carcinoma of the Lung." Application has been made for two credit-hours in Category I of the AMA Physician's Recognition Award. For additional information, please communicate with the Delaware-Raritan Lung Association, 29 Emmons Drive, Princeton 08540.

Mental Health Professionals and Lawyers

The annual Lewis H. Loesser Memorial Lecture will be held on Wednesday, November 3 at 8 p.m. at Seton Hall University in South Orange. Professor Alexander Brooks of the Rutgers Law School will make the presentation — "Mental Health Professionals and Lawyers — Allies or Adversaries?" Dr. Claudwell Thomas, Professor of Psychiatry at CMDNJ, will be the discussor. Admission is free and application has been made for accreditation in AMA Category I. Sponsors are the Essex County Mental Health Association, the New Jersey Psychiatric Association, the New Jersey Psychological Association, and the New Jersey Nurses' Association. For additional information, please communicate with the Essex County Mental Health Association, 424 Main Street, East Orange (201) 677-1540.

Pediatric and Adolescent Echocardiography Course

A course in pediatric and adolescent echocardiography will be presented on November 13 and 14 (the two days preceeding the American Heart Association meeting) in Miami Beach, Florida. The course is sponsored by the American Society of Echocardiography and Postgraduate Educational Division of H.E.L.P. and is approved for AMA Category I continuing education credit. Further information may be obtained from course director Stanley J. Goldberg, M.D., The University of Arizona, 1501 N. Campbell, Tucson, Arizona 85724.

Graduate Seminar on St. Croix

The Virgin Islands Medical Society, in association with the University of Pennsylvania School of Medicine, will present a mid-winter clinical conference at the Buccaneer Hotel on St.

Croix, January 13 through 15, 1977. Lectures and seminars will be offered in general practice, internal medicine, general surgery, obstetrics and gynecology, and pediatrics. The program is acceptable for 14 credit hours in Category I of the AMA Physician's Recognition Award. Registration is limited and early registration is suggested. For further information please communicate with James S. Glenn, M.D., Chairman, Committee on Continuing Medical Education, U.S. Virgin Islands Medical Society, P.O. Box 520, Christiansted, St. Croix, U.S.V.I. 00820.

Aspen Radiology Conference

The annual Aspen Radiology Conference, to be held February 28 to March 4, 1977, at the Aspen Institute for Humanistic Studies, Aspen, Colorado, is designed for physicians and scientists interested in diagnostic radiology, nuclear radiology, and diagnostic ultrasound and will explore the impact of clinical and technological advances on radiologic practice.

The topics for discussions will include advances in bone, cardiovascular, gastrointestinal, obstetric/gynecologic, and neurologic radiology involving a tri-radiological approach. The advances in the three radiological subdivisions relating to these topics will be surveyed as refresher courses in independent diagnostic radiology, nuclear radiology, and diagnostic ultrasound sessions. There will be an independent course in diagnostic ultrasound and a plenary session on total body CT scanning, comparing this modality with diagnostic ultrasound and nuclear imaging.

Further information may be obtained from Emanuel Salzman, M.D., Conference Chairman, Division of Radiology, Beth Israel Hospital, Denver, Colorado 80204.

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Personal Items

Dr. Seymour Charles
Recipient of the Ill Award

On May 26, on the occasion of the Awards Dinner of the Academy of Medicine, Dr. Seymour Charles of South Orange was the recipient of the Edward J. Ill Award. Dr. Charles was honored for his dedication and extraordinary service to the medical profession and to the citizens of New Jersey. As a pediatrician, one of his prime concerns has been child transportation safety and in the mid-1960's he was instrumental in organizing physicians to protest the lack of safety engineering in automobiles. From this emerged the national organization, Physicians for Automotive Safety, whose efforts have effected the now readily available child restraints and safety features. Dr. Charles is producer and moderator of a weekly radio program, Community Health Hour, sponsored by the Essex County Medical Society, and in 1970 was instrumental in organizing (and is now chairman of its Board) the Lyons Family Health Center in Newark. Dr. Charles is Assistant Clinical Professor in both the departments

of pediatrics and preventive medicine at New Jersey Medical School, CMDNJ, and is chief of pediatrics at the Newark Beth Israel Medical Center.

Grant to Dr. Fonda for Retinitis Pigmentosa Study

Dr. Gerald E. Fonda of Short Hills has been awarded a grant by the National Retinitis Pigmentosa Foundation of Baltimore, Maryland. Dr. Fonda, one of the nation's leading authorities on minimal vision problems, is director of the Low Vision Rehabilitation Service at St. Barnabas Medical Center in Livingston.

The project that Dr. Fonda will undertake for the RP Foundation is entitled "Characteristics and Low Vision Corrections in Retinitis Pigmentosa." Dr. Fonda is active in the evaluation of optical aids for enlarging the field of vision for patients with tunnel vision, most often caused by RP. He is working closely with investigators in Sweden and England on this project.

Responsibility for Reporting Theft of Controlled Substances

The Drug Enforcement Administration (DEA) wishes to remind physicians of their duty to report all thefts of controlled substances to the nearest DEA Office. Title 21 of the Code of Federal Regulations, Section 1301.74 requires the registrant to notify the Drug Enforcement Administration of any theft of controlled substances immediately upon discovery. DEA's form 106 should be used for reporting a theft or loss. This form not only serves to notify the DEA but a copy retained by the physician is his official record to account for the disposition of

the controlled substances. Without this form, the physician may be held responsible for undocumented losses.

Copies of the DEA-106 may be obtained from the Drug Enforcement Administration office in Philadelphia (600 Arch Street, Room 10224, Philadelphia, Pennsylvania 19106, telephone 215-597-9540).

NB: A supply of the form also has been made available to MSNJ (Journal office).

Before prescribing, please consult
the product information, a sum-
mary of which follows:

Indications: Tension and anxiety
somatic complaints which are
manifestants of emotional factors; psy-
chotic states manifested by tension,
apprehension, fatigue, depres-
sion or agitation; symptomatic
acute agitation, tremor, delirium
and hallucinosis due to acute
withdrawal; adjunctively in skele-
tal spasm due to reflex spasm to
pathology, spasticity caused by
motor neuron disorders, athetosis,
Parkinson syndrome, convulsive disorders
(sole therapy).

Contraindicated: Known hypersensi-
tivity to the drug. Children under 6
months of age. Acute narrow angle glau-
coma. May be used in patients with open
angle glaucoma who are receiving appro-
priate therapy.

Warnings: Not of value in psychotic
states. Caution against hazardous
activities requiring complete mental
alertness. When used adjunctively in con-
vulsive disorders, possibility of increase
in frequency and/or severity of grand mal
seizures may require increased dosage of
anticonvulsant medication;
withdrawal may be associated
with temporary increase in frequency
and severity of seizures. Advise
against simultaneous ingestion of alcohol
with CNS depressants. Withdrawal
symptoms (similar to those with barbitu-
rates and alcohol) have occurred follow-
ing abrupt discontinuance (convulsions,
headache, abdominal and muscle cramps,
fever, sweating). Keep addiction-
prone individuals under careful surveil-
lance because of their predisposition to
dependence. In preg-
nancy, administration or women of childbearing
age may have potential benefit against
anxiety, but hazard.

Precautions: If combined with other
CNS depressants or anticonvulsants, con-
sider carefully pharmacology of agents
combined; drugs such as phenothiazines,
barbiturates, MAO inhibitors
after antidepressants may potentiate
effect. Usual precautions indicated in
patients severely depressed, or with latent
depression, or with suicidal tendencies.
Usual precautions in impaired
hepatic function. Limit dosage to
effective amount in elderly and
avoid to preclude ataxia or over-

Side Effects: Drowsiness, confusion,
hypotension, changes in libido,
fatigue, depression, dysarthria,
skin rash, ataxia, constipation,
urinary incontinence, changes in sali-
vated speech, tremor, vertigo,
retention, blurred vision. Para-
reactions such as acute hyper-
sensitivity states, anxiety, hallucinations,
muscle spasticity, insomnia,
sleep disturbances, stimulation
often reported; should these occur,
discontinue drug. Isolated reports of neu-
ritis, jaundice; periodic blood counts
and function tests advisable during
long-term therapy.

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the patient's pattern of overreaction to stress
affects his ability to function

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10-mg tablets

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MEETINGS OF MEDICAL INTEREST

This listing is compiled through the cooperation of the Committee on Medical Education of The Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the College of Medicine and Dentistry of New Jersey. For information on accreditation, please contact the sponsoring organization(s).

September

- 15 **Jejuno-Ileal Shunt: Anesthesia and Surgery Problems**
7-9:30 p.m. — St. Michael's Medical Center, Newark
(Sponsored by Educational Council for Anesthesiology)
- 15 **Symposium on T.I.A.**
1-3 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital and AAFP)
- 15 **Neurology: A Workshop**
7-10 p.m. — V.A. Hospital, East Orange (Every 3rd Wednesday — 9/15/76 to 6/15/77)
(Sponsored by East Orange V.A. Hospital and CMDNJ)
- 15 **Interesting Chest X-Rays**
9:30-11 a.m. — Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital)
- 15 **Complications of Myocardial Infarction**
8 a.m. — Southern Ocean County Hospital, Manahawkin
(Sponsored by Burlington County Memorial Hospital)
- 15 **Proper Use of Antibiotics**
1:30 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
- 15 **Special Rounds, General Surgery and Specialities**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 15 **Respiratory Failure**
11:30 a.m.-12:30 p.m. — V.A. Hospital, East Orange
(Sponsored by V.A. Hospital, East Orange)
- 15 **Papilledema in Children**
5-8:30 p.m. — Hunterdon Medical Center, Flemington
(Sponsored by Hunterdon Medical Center and AAFP)
- 15 **Cardiac Complications of Anti-depressants and Tranquilizing Drugs**
3-4:30 p.m. — Fair Oaks Hospital, Summit
(Sponsored by Fair Oaks Hospital)
- 15 **Socio-Medical Management of the Geriatric Patient**
12:45-4:45 p.m. — Statler Hilton Hotel, New York
(Sponsored by American Geriatrics Society and NYU)
- 16 **Socio-Medical Management of the Geriatric Patient**
1:30-5:30 p.m. — Holiday Inn, City Line Avenue, Philadelphia
(Sponsored by American Geriatrics Society, Norristown State Hospital, and NYU)
- 16 **History of Allergy and Scope of Problem**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark)
- 16 **Medical Care Evaluation Seminar**
11 a.m.-12 noon — Passaic General Hospital
(Sponsored by Passaic Valley P.S.R.O.)
- 17 **"In My Becoming I Am What I Was" (On Aging)**
9-10:30 p.m. — The Manor, West Orange
(Sponsored by N.J. Psychiatric Association)
- 17 **Endocrinology**
12 noon — Freehold Area Hospital
(Sponsored by AMNJ and AAFP)
- 17 **Normal Personality Development**
1:30-2:30 p.m. — Trenton Psychiatric Hospital
Neuroanatomy and Neuropathology
2:45-3:45 p.m. — Trenton Psychiatric Hospital
Clinical Neurology
4-5 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital)
- 17- **New Jersey Orthopaedic Society, Annual Meeting**
18 8:30 a.m.-1:30 p.m. (both days) — Sea Island, Georgia
- 18- **Pediatric Critical Care**
19 9 a.m.-12 noon (18th) and 10 a.m.-2 p.m. (19th) Jersey Shore Medical Center, Neptune
(Sponsored by Jersey Shore Medical Center)
- 21 **Hepatitis**
12 noon — St. Mary's Hospital, Orange
(Sponsored by AMNJ and AAFP)
- 22 **Lung Cancer — End Results**
12 noon-1 p.m. — Englewood Hospital
(Sponsored by Englewood Hospital)
- 22 **Dialysis-Related Problems**
1-5 p.m. — Jersey City Medical Center
(Sponsored by Nephrology Society)
- 22 **Alcoholism**
1 p.m. — Trenton Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
- 22 **Understanding and Treatment of Ketoacidosis**
9:30-11 a.m. — Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital)
- 22 **Special Rounds, Internal Medicine**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 22 **Surgery of Acquired Heart Disease in Adult**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 22 **Pap Smear: Interpretation and Followup**
1-3 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital and AAFP)

- 23 **Pediatric Pulmonary Conference**
11-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark)
 - 23 **Malpractice Problems in Medicine**
12 noon-1 p.m. — St. Mary's Hospital, Orange
(Sponsored by St. Mary's Hospital)
 - 23 **Ultrasound and Neoplasia**
7:30-9:30 p.m. — East Orange General Hospital
(Sponsored by New Jersey Institute of Ultra Sound)
 - 24 **Normal Personality Development**
1:30-2:30 p.m. — Trenton Psychiatric Hospital
Neuroanatomy and Neuropathology
2:45-3:45 p.m. — Trenton Psychiatric Hospital
Clinical Neurology
4-5 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital)
 - 28 **Current Status of the Oral Hypoglycemics**
8-9:30 p.m. — Warren Hospital, Phillipsburg
(Sponsored by Warren Hospital)
 - 28 **Non-Hodgkins Lymphoma Symposium**
12:30-3:30 p.m. — V.A. Hospital, East Orange
(Sponsored by East Orange V.A. Hospital and the Leukemia Society)
 - 29 **Depression: Sleep Disorders**
11 a.m.-1:30 p.m. — Camden County Psychiatric Hospital, Lakeland
(Sponsored by Camden County Psychiatric Hospital)
 - 29 **Cardiac Arrhythmia**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
 - 29 **Electro-myelography**
1-3 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital and AAFP)
 - 29 **Relevancy of Renin and Aldosterone in Hypertension**
9:30-11 a.m. — Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital)
 - 29 **Current Treatment of Burns**
1:30 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
 - 29 **Diabetes**
3 p.m. — Fair Oaks Hospital, Summit
(Sponsored by AMNJ and AAFP)
 - 30 **Basic Concepts in Immunology**
11-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark)
- Oct.
- 1 **Diabetes**
8:30 a.m. — United Hospitals of Newark
(Sponsored by AMNJ and AAFP)
 - 1 **Normal Personality Development**
1:30-2:30 p.m. — Trenton Psychiatric Hospital
Neuroanatomy and Neuropathology
2:45-3:45 p.m. — Trenton Psychiatric Hospital
Clinical Neurology
4-5 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital)
- 1 **Child Testicle Equation**
8:30-10:30 p.m. — Hackensack Hospital
(Sponsored by the New Jersey Psychoanalytic Society)
 - 4-8 **Obstetrics and Gynecology: Clinical and Histopathological Survey**
St. Barnabas Medical Center, Livingston
(Sponsored by St. Barnabas Medical Center)
 - 4 **Peripheral Vascular Disease**
8 p.m. — Community Memorial Hospital, Toms River
(Sponsored by AMNJ and AAFP)
 - 5 **Psychiatric Case Conferences**
7:30-9:30 a.m. — Trenton Psychiatric Hospital
(Weekly 9/5/76 — 10/4/77)
(Sponsored by Trenton Psychiatric Hospital)
 - 5 **Cardiac Arrhythmias**
11 a.m. — Greystone Park Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
 - 6 **Hypertension 1976 — An Overview**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
 - 6 **Diagnostic Aspects of Pleural Effusion**
9:30-11 a.m. — Bergen Pines County Hospital Auditorium
(Sponsored by Bergen Pines County Hospital)
 - 6 **Rational Use of Antibiotics**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital)
 - 6 **Current Treatment of Burns**
1 p.m. — Christ Hospital, Jersey City
(Sponsored by AMNJ and AAFP)
 - 6 **Lower Extremity Amputation and Replacement**
9 a.m.-3 p.m. — East Orange V.A. Hospital
(Sponsored by East Orange V.A. Hospital and N.J. Society of Physical Medicine and Rehabilitation)
 - 6 **Expanding Dimensions of Consciousness**
9 a.m.-5:30 p.m. — Carrier Clinic, Belle Mead
(Sponsored by Carrier Clinic Foundation and AAFP)
 - 6 **Special Rounds, Pediatrics**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 7 **Anaphylactic or Type I Reactions**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark)
 - 8 **Current Concepts of Depression**
11 a.m.-12 noon — Ciba-Geigy, Summit
(Sponsored by Ciba-Geigy, Pharmaceuticals Division)
 - 8 **Emotionally Disturbed Child**
1:30-2:30 p.m. — Trenton Psychiatric Hospital
Neuroanatomy and Neuropathology
2:45-3:45 p.m. — Trenton Psychiatric Hospital
Clinical Neurology
4-5 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital)
 - 12 **Pulmonary Embolism**
8 a.m. — S. Ocean Co. Hospital, Manahawkin
(Sponsored by Burlington County Memorial Hospital and AAFP)

- 12 **Arthritis**
8 p.m. — Paul Kimball Hospital, Lakewood
(Sponsored by AMNJ and AAFP)
- 12 **Laboratory Interpretations**
9 p.m. — Bayonne Hospital
(Sponsored by AMNJ and AAFP)
- 12 **Clinical Diagnosis and Management of Shock**
8-9 p.m. — Irvington General Hospital
(Sponsored by Irvington General Hospital)
- 13 **Management of Depression**
1-2 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital)
- 13 **Thyroid Disease**
1-3 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital)
- 13 **Management of the Violent Patient**
1-2 p.m. — V.A. Hospital, Lyons
(Sponsored by Lyons V.A. Hospital)
- 13 **Current Treatment of Burns**
1:30 p.m. — John E. Runnells Hospital, Berkeley Heights
(Sponsored by AMNJ and AAFP)
- 13 **Vasodilator Therapy in Chronic Heart Failure**
9:30-11 a.m. — Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital)
- 13 **Cardiac Arrhythmias**
1:30 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
- 13 **Hyperparathyroidism and Vitamin D**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
- 13 **Nephrolithiasis**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 13 **Special Rounds, Obstetrics/Gynecology**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 13 **Alienation in Adolescents**
3-4:30 p.m. — Fair Oaks Hospital, Summit
(Sponsored by Fair Oaks Hospital)
- 14 **Mediators of the Allergic Reactions**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
- 15 **Emotionally Disturbed Child**
1:30-2:30 p.m. — Trenton Psychiatric Hospital
Neuroanatomy and Neuropathology
2:45-3:45 p.m. — Trenton Psychiatric Hospital
Clinical Neurology
4-5 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital)
- 15 **Emergency Medicine**
12 noon — Freehold Area Hospital
(Sponsored by AMNJ and AAFP)
- 15 **Allergy**
4:30 p.m. — Salem County Medical Society
(Sponsored by AMNJ and AAFP)
- 16 **Anesthesiology — Respiratory Care Symposium**
8:30 a.m.-12:30 p.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital)
- 18 **Management of Hypertension**
1 p.m. — Ancora Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
- 19 **Oncology — Current Chemotherapy and Radiation**
12 noon — St. Mary's Hospital, Orange
(Sponsored by AMNJ and AAFP)
- 19 **Otoplasty**
6-10 p.m. — Pascack Valley Hospital, Westwood
(Sponsored by Bergen County Society of Otolaryngologists)
- 20 **Drug Addiction**
1 p.m. — Trenton Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
- 20 **Proper Selection of Psychotropic Drugs**
9:30-11 a.m. — Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital)
- 20 **Fistula and Diaphragmatic Hernia**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
- 20 **Special Rounds, General Surgery and Specialties**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 20 **Antibiotic Therapy in Renal Disease**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 20 **Early Detection of Lung Cancer**
11:30 a.m.-12:30 p.m. — V.A. Hospital, East Orange
(Sponsored by East Orange V.A. Hospital)
- 20 **Medical Conditions Disguised as Dermatological Problems**
1-3 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital and AAFP)
- 20 **Halogenated Anesthetics**
8 a.m. — Southern Ocean County Hospital, Manahawkin
(Sponsored by Burlington County Memorial Hospital and AAFP)
- 21 **Clinical Medical Ultrasound**
All day — Somerset Hospital
(Sponsored by AMNJ and AAFP)
- 21 **Immunodeficiency Disorders**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark)
- 22 **Psychodynamics and Psychotherapy of Psychiatric Disorders**
1:30-2:30 p.m. — Trenton Psychiatric Hospital
Neuroanatomy and Neuropathology
2:45-3:45 p.m. — Trenton Psychiatric Hospital

- Clinical Neurology**
4-5 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital)
- 26 **Alcoholism**
12 noon — Hospital Center at Orange
(Sponsored by AMNJ and AAFP)
- 26 **Clinical Pathological Conference**
Every Tuesday, 10/26/76 to 10/25/77 — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital)
- 27 **Recent Advances in Para-Psychology and Its Application to Psychiatry**
8:30-10:30 p.m. — Mayfair Farms, West Orange
(Sponsored by New Jersey Psychiatric Association)
- 27 **Laboratory Interpretations**
3 p.m. — Fair Oaks Hospital, Summit
(Sponsored by AMNJ and AAFP)
- 27 **Coronary Artery Disease**
1:30 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
- 27 **Sexual Dysfunction**
9:30-11 a.m. — Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital)
- 27 **Lymphomas**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
- 27 **Dermatologic Manifestations of Internal Malignancy**
12 noon-1 p.m. — Englewood Hospital
(Sponsored by Englewood Hospital)
- 27 **Special Rounds, Internal Medicine**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 27 **Pancreatitis**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 28 **Pediatric Pulmonary Conference**
11-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
- 29 **Psychodynamics and Psychotherapy of Psychiatric Disorders**
1:30-2:30 p.m. — Trenton Psychiatric Hospital
Neuroanatomy and Neuropathology
2:45-3:45 p.m. — Trenton Psychiatric Hospital
Clinical Neurology
4-5 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital)
- 29- **Clinical Heart Disease**
- 31 **Holiday Inn, Saddle Brook**
(Sponsored by St. Michael's Medical Center)
- 30 **Clinical Genetics — Update '76**
All Day — Morristown Memorial Hospital, Morristown
(Sponsored by Morristown Memorial Hospital)
- Nov.
- 1 **Proper Use of Antibiotics**
1 p.m. — Ancora Psychiatric Hospital, Hammonton
(Sponsored by AMNJ and AAFP)
- 1 **Lung Cancer**
8 p.m. — Community Memorial Hospital, Toms River
(Sponsored by AMNJ and AAFP)
- 2 **Cardiac Rehabilitation**
11 a.m. — Greystone Park Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
- 3 **Clinical Endocrinology**
1 p.m. — Christ Hospital, Jersey City
(Sponsored by AMNJ and AAFP)
- 3 **Histocompatibility and the Recognition of Self**
9:30-11 a.m. — Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital)
- 3 **Selected Topics in Gastroenterology**
8-10 p.m. — Somerset Hospital
(Sponsored by N.J. Gastroenterology Society)
- 3 **Intraocular Lens Implantation**
5-8:30 p.m. — Hunterdon Medical Center, Flemington
(Sponsored by Hunterdon Medical Center)
- 3 **Acute Kidney Disease**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
- 3 **Mental Health Professionals and Lawyers — Allies or Adversaries**
8-10 p.m. — Seton Hall University, South Orange
(Sponsored by N.J. Psychiatric Association)
- 3 **Special Rounds, Pediatrics**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 3 **New Horizons in Diabetes**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 4 **Evaluations of Immunology Reactions**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
- 5 **Clinical Immunology**
8:30 a.m. — United Hospitals of Newark
(Sponsored by AMNJ and AAFP)
- 5 **Psychodynamics and Psychotherapy of Psychiatric Disorders**
1:30-2:30 p.m. — Trenton Psychiatric Hospital
Neuroanatomy and Neuropathology
2:45-3:45 p.m. — Trenton Psychiatric Hospital
Clinical Neurology
4-5 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital)
- 9 **Hyperparathyroidism**
8 a.m. — Southern Ocean County Hospital, Manahawkin
(Sponsored by Burlington County Memorial Hospital and AAFP)

- 9 **Bleeding Diseases**
8 p.m. — Paul Kimball Hospital, Lakewood
(Sponsored by AMNJ and AAFP)
- 9 **Proper Use of Blood Gases**
9 p.m. — Bayonne Hospital
(Sponsored by AMNJ and AAFP)
- 10 **Suicidology**
3 p.m. — Fair Oaks Hospital, Summit
(Sponsored by AMNJ and AAFP)
- 10 **Diagnosis of the Anemic Patient**
1:30 p.m. — Runnells Hospital, Berkeley Heights
(Sponsored by AMNJ and AAFP)
- 10 **Clinical Endocrinology**
1:30 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
- 10 **Thyroid Disease**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
- 10 **Unstable Angina**
9:30-11 a.m. — Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital)
- 10 **Cor Pulmonale**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 10 **Special Rounds, Obstetrics and Gynecology**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 10 **Parenteral Nutrition — Hyperalimentation**
1-3 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital and AAFP)
- 10 **Annual Scientific Meeting, N.J. Chapter AAP**
1-5 p.m. and 8-9 p.m. — Ramada Inn, Clark
(Sponsored by N.J. Chapter, American Academy of Pediatrics)
- 11 **Pathophysiology of Asthma**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMNJ)
- 12 **Psychodynamics and Psychotherapy of Psychiatric Disorders**
1:30-2:30 p.m. — Trenton Psychiatric Hospital
Neuroanatomy and Neuropathology
2:45-3:45 p.m. — Trenton Psychiatric Hospital
Clinical Neurology
4-5 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital)
- 12 **Psychoanalytic Psychophysiological Model for Chemotherapy of Psychosomatic Illness**
8:30-10:30 p.m. — Hackensack Hospital
(Sponsored by N.J. Psychoanalytic Association)
- 13 **Diagnosis and Prevention of Sports Injuries**
9 a.m.-12 noon — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital)
- 16 **Problems in a Student Health Service**
7:45-10 p.m. — 561 So. Orange Avenue, So. Orange
(Sponsored by the Journal Club of Greater Newark)
- 16 **Oncology — Breast and Lung Cancer**
12 noon — St. Mary's Hospital, Orange
(Sponsored by AMNJ and AAFP)
- 17 **Shock**
1 p.m. — Trenton Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
- 17 **Hepatitis B Immune Globulin in Hepatitis B Infections**
9:30-11 a.m. — Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital)
- 17 **Effect of Age on the Response to Cardio-Active Agents**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
- 17 **Arthroscopy**
8 a.m. — Southern Ocean County Hospital, Manahawkin
(Sponsored by Burlington County Memorial Hospital and AAFP)
- 17 **Bullae, Blebs, Cysts: Surgical Considerations**
11:30 a.m.-12:30 p.m. — V.A. Hospital, East Orange
(Sponsored by East Orange V.A. Hospital)
- 17 **Intestinal Absorption and Malabsorption**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 17 **Special Rounds, General Surgery and Specialties**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 17 **Neurosurgical Treatment of Pain**
1-2 p.m. — V.A. Hospital, Lyons
(Sponsored by Lyons V.A. Hospital)
- 18 **Pulmonary Function by Bronchspirometry**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
- 18 **Dermal Ulcers and Necrotic Burns**
12 noon-1 p.m. — St. Mary's Hospital, Orange
(Sponsored by St. Mary's Hospital)
- 19 **Gastrointestinal Bleeding**
12 noon — Freehold Area Hospital
(Sponsored by AMNJ and AAFP)
- 19 **Clinical Endocrinology**
4:30 p.m. — Salem County Medical Society
(Sponsored by AMNJ and AAFP)
- 19 **Psychodynamics and Psychotherapy of Psychiatric Disorders**
1:30-2:30 p.m. — Trenton Psychiatric Hospital
Neuroanatomy and Neuropathology
2:45-3:45 p.m. — Trenton Psychiatric Hospital
Clinical Neurology
4-5 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital)
- 23 **Dermatology**
12 noon — Hospital Center at Orange
(Sponsored by AMNJ and AAFP)

- 23 Psychopathology of Sexual Dysfunction**
2-4 p.m. — Camden County Psychiatric Hospital
(Sponsored by Camden County Psychiatric Hospital)
- 24 Occupational Medicine**
3-4:30 p.m. — Fair Oaks Hospital, Summit
(Sponsored by Fair Oaks Hospital)
- 24 Hyperlipemia, 1976**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 24 Special Rounds, Internal Medicine**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 24 Clinical Immunology**
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
- 24 Rheumatoid Disease**
9:30-11 a.m. — Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital)
- 24 Mycosis Fungoides and Relevant Skin Lymphomas**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
- 24 Laparoscopy**
12 noon-1 p.m. — Englewood Hospital
(Sponsored by Englewood Hospital)

Dec.

- 1 Swine Flu — 1976**
9:30-11 a.m. — Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital)
- 1 Clinical Immunology**
1 p.m. — Christ Hospital, Jersey City
(Sponsored by AMNJ and AAFP)
- 1 Hypoglycemia As a Clinical Problem**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
- 1 Advances in Nutrition**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 1 Special Rounds, Pediatrics**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 1 Management of Diabetes Mellitus**
1:30-2:30 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital)
- 1 Selected Topics in Gastroenterology**
8-10 p.m. — Overlook Hospital, Summit
(Sponsored by N.J. Gastroenterology Society)
- 2 Blood Gases**
11-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
- 3 Surgical Management of Ulcerative Colitis**
8:30 a.m. — United Hospitals of Newark
(Sponsored by AMNJ and AAFP)
- 3 Psychodynamics and Psychotherapy of Psychiatric Disorders**
1:30-2:30 p.m. — Trenton Psychiatric Hospital

- Neuroanatomy and Neuropathology**
2:45-3:45 p.m. — Trenton Psychiatric Hospital
Clinical Neurology
4-5 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital)
- 6 Laboratory Interpretations**
1-3 p.m. — Ancora Psychiatric Hospital, Hammonton
(Sponsored by AMNJ and AAFP)
- 6 Alcoholism**
8 p.m. — Community Memorial Hospital, Toms River
(Sponsored by AMNJ and AAFP)
- 7 Congestive Heart Failure**
11 a.m. — Greystone Park Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
- 8 Chronic Renal Failure**
1:30 p.m. — Runnells Hospital, Berkeley Heights
(Sponsored by AMNJ and AAFP)
- 8 Emergency Medicine**
1-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
- 8 Hormones and Cancer**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
- 8 Screening for Colon Cancer**
9:30-11 a.m. — Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital)
- 8 Philosophical Background of Transactional Analysis, Part I**
3-4:30 p.m. — Fair Oaks Hospital, Summit
(Sponsored by Fair Oaks Hospital)
- 8 Psychoactive Medications**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 8 Special Rounds, Obstetrics and Gynecology**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 9 Definitions of Asthma**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
- 14 Hematuria and Its Causes**
8 a.m. — Southern Ocean County Hospital, Manahawkin
(Sponsored by Burlington County Memorial Hospital and AAFP)
- 14 Burns**
8 p.m. — Paul Kimball Hospital, Lakewood
(Sponsored by AMNJ and AAFP)
- 14 Thyroid Diseases**
9 p.m. — Bayonne Hospital
(Sponsored by AMNJ and AAFP)
- 15 Complications of Alcoholism**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 15 Hypersensitivity and Immunity**
11:30 a.m.-12:30 p.m. — V.A. Hospital, East Orange
(Sponsored by East Orange V.A. Hospital)

- 15 **Special Rounds, General Surgery and Specialties**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 15 **Psychiatric Aspect of Endocrine Disorders**
1 p.m. — Trenton Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
 - 15 **Prolapse of the Mitral Valve**
9:30-11 a.m. — Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital)
 - 15 **Facial Trauma and Reconstructive Surgery**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
 - 16 **Inhalation Therapy and O₂ and Mist Therapy**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
 - 17 **Bleeding Diseases**
12 noon — Freehold Area Hospital
(Sponsored by AMNJ and AAFP)
 - 21 **Infectious Diseases**
12 noon — St. Mary's Hospital, Orange
(Sponsored by AMNJ and AAFP)
 - 21 **Chronic Renal Failure**
12 noon — Hospital Center at Orange
(Sponsored by AMNJ and AAFP)
 - 22 **Gastrointestinal Bleeding**
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
 - 22 **Computerized Tomography**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
 - 22 **When to Refer to the Geneticist**
9:30-11 a.m. — Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital)
 - 22 **Headaches in Children**
8 a.m. — Southern Ocean County Hospital, Manahawkin
(Sponsored by Burlington County Memorial Hospital and AAFP)
 - 22 **Philosophical Background of Transactional Analysis, Part II**
3-4:30 p.m. — Fair Oaks Hospital, Summit
(Sponsored by Fair Oaks Hospital)
 - 22 **The Aging Heart**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
 - 22 **Special Rounds, Internal Medicine**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 23 **Pediatric Pulmonary Conference**
11-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
 - 29 **Clinical Pathology Conference**
9:30-11 — Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital)
 - 30 **Hospital Management of Childhood Asthma**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
- 1977
Jan.
- 3 **Diagnosis and Treatment of Shock**
1 p.m. — Ancora Psychiatric Hospital, Hammonton
(Sponsored by AMNJ and AAFP)
 - 3 **Pacemakers**
8 p.m. — Community Memorial Hospital, Toms River
(Sponsored by AMNJ and AAFP)
 - 4 **Coronary Artery Disease**
11 a.m. — Greystone Park Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
 - 5 **Cancer Research**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
 - 5 **Special Rounds, Pediatrics**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 5 **Emergency Medicine**
1 p.m. — Christ Hospital, Jersey City
(Sponsored by AMNJ and AAFP)
 - 5 **Clinical Endocrinology**
3 p.m. — Fair Oaks Hospital, Summit
(Sponsored by AMNJ and AAFP)
 - 5 **Fiberoptic Bronchoscopy**
9:30-11 a.m. — Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital)
 - 5 **Myasthenia Gravis**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
 - 5 **Selected Topics in Gastroenterology**
8-10 p.m. — Medical Center, Princeton
(Sponsored by N.J. Gastroenterology Society)
 - 6 **The Allergic Child**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
 - 7 **Indications for Cardiac Surgery in Rheumatic and Congenital Heart Disease**
8:30 a.m. — United Hospitals of Newark
(Sponsored by AMNJ and AAFP)
 - 11 **Pre-Hospital Coronary Care**
8 p.m. — Paul Kimball Hospital, Lakewood
(Sponsored by AMNJ and AAFP)
 - 11 **Sports Medicine**
9 p.m. — Bayonne Hospital
(Sponsored by AMNJ and AAFP)

- 12 **Weakness and Fatigue**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
 - 12 **Special Rounds, Obstetrics and Gynecology**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 12 **Clinical Immunology**
11:30 a.m. — Rahway Hospital
(Sponsored by AMNJ and AAFP)
 - 12 **Surgery in Ulcerative Colitis**
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
 - 12 **Endocrine Diseases of the Male and Female Gonads**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
 - 13 **Chronic Chest Disease in Children**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMNJ)
 - 18 **Endotoxic Shock**
12 noon — St. Mary's Hospital, Orange
(Sponsored by AMNJ and AAFP)
 - 19 **Hepatitis**
1 p.m. — Trenton Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
 - 19 **Acid Base Disturbances**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
 - 19 **Out-Patient Management of COPD**
11:30 a.m.-12:30 p.m. — V.A. Hospital, East Orange
(Sponsored by East Orange V.A. Hospital)
 - 19 **Pathophysiology of Anemia**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
 - 19 **Special Rounds, General Surgery and Specialties**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 20 **Asthma**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
 - 21 **Clinical Immunology**
12 noon — Freehold Area Hospital
(Sponsored by AMNJ and AAFP)
 - 21 **Bleeding Diseases**
4:30 p.m. — Salem County Medical Society
(Sponsored by AMNJ and AAFP)
 - 25 **Child Abuse and Neglect**
8 p.m. — Warren Hospital, Phillipsburg
(Sponsored by AMNJ and AAFP)
 - 26 **Hepatitis**
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
 - 26 **Malignant Melanomas**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
 - 26 **Gram Negative Infections in Surgery**
9-11 a.m. — Auditorium, Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
 - 26 **Special Rounds, Internal Medicine**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 27 **Pediatric Pulmonary Conference**
11-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
- Feb.
- 1 **Pre-Hospital Coronary Care**
11 a.m. — Greystone Park Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
 - 2 **Laboratory Interpretations**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
 - 2 **Special Rounds, Pediatrics**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 2 **Gastrointestinal Bleeding**
1 p.m. — Christ Hospital, Jersey City
(Sponsored by AMNJ of New Jersey and AAFP)
 - 2 **Gout and Pseudogout**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
 - 3 **Hypersensitivity Pneumonitis**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
 - 4 **Laboratory Interpretations**
8:30 a.m. — United Hospitals of Newark
(Sponsored by AMNJ and AAFP)
 - 7 **Coronary Artery Disease**
1 p.m. — Ancora Psychiatric Hospital, Hammonton
(Sponsored by AMNJ and AAFP)
 - 7 **Vascular Surgery**
8 p.m. — Community Memorial Hospital, Toms River
(Sponsored by AMNJ and AAFP)
 - 8 **Cerebral Vascular Disease**
8 p.m. — Paul Kimball Hospital, Lakewood
(Sponsored by AMNJ and AAFP)
 - 8 **Acute Renal Failure**
9 p.m. — Bayonne Hospital
(Sponsored by AMNJ and AAFP)
 - 9 **Management of Hepatitis**
11:30 a.m. — Rahway Hospital
(Sponsored by AMNJ and AAFP)
 - 9 **Current Chemotherapy**
1:30 p.m. — Runnells Hospital, Berkeley Heights
(Sponsored by AMNJ and AAFP)

- 9 **Fluid and Electrolyte Imbalance**
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
 - 9 **Hyperaldosteronism**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
 - 9 **Common Intestinal Parasites**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
 - 9 **Special Rounds, Obstetrics and Gynecology**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 10 **Aeroallergens, Air Pollutants and Respiratory Disease**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
 - 15 **Thyroid Disease**
12 noon — St. Mary's Hospital, Orange
(Sponsored by AMNJ and AAFP)
 - 15 **Anesthetic Air Pollution in the Operatory**
8:30 p.m. (preceded by dinner at 6 p.m.) — Fireside Inn, Rochelle Park
(Sponsored by Dental Section, AMNJ)
 - 16 **Thanatology**
3 p.m. — Fair Oaks Hospital, Summit
(Sponsored by AMNJ and AAFP)
 - 16 **The Violent Patient**
1 p.m. — Trenton Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
 - 16 **Congestive Heart Failure**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
 - 16 **Clinical Physiology of the Control of Breathing**
11:30 a.m.-12:30 p.m. — V.A. Hospital, East Orange
(Sponsored by East Orange V.A. Hospital)
 - 16 **Psychosomatic Problems in Children**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
 - 16 **Special Rounds, General Surgery and Specialties**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 17 **Molds and Pollens**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
 - 18 **Sports Medicine**
4:30 p.m. — Salem County Medical Society
(Sponsored by AMNJ and AAFP)
 - 18 **Blood Gases**
12 noon — Freehold Area Hospital
(Sponsored by AMNJ and AAFP)
 - 22 **Current Treatment of Burns**
8 p.m. — Warren Hospital, Phillipsburg
(Sponsored by AMNJ and AAFP)
 - 23 **Breast Cancer**
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
 - 23 **Adolescent Medicine**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
 - 23 **Common Pediatric Orthopedic Problems**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
 - 23 **Special Rounds, Internal Medicine**
10:30 a.m. 12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 24 **Pediatric Pulmonary Conference**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
- Mar.
- 1 **Fluid and Electrolyte Imbalance**
11 a.m. — Greystone Park Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
 - 2 **Infertility**
1 p.m. — Christ Hospital, Jersey City
(Sponsored by AMNJ and AAFP)
 - 2 **Fluid and Electrolyte Imbalance**
11:30 a.m. — Rahway Hospital
(Sponsored by AMNJ and AAFP)
 - 2 **Coagulopathies and Dysproteinemia: Multiple Myeloma and Waldenstroms**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
 - 2 **Child Health**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
 - 2 **Special Rounds, Pediatrics**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 2 **Selected Topics in Gastroenterology**
8-10 p.m. — Valley Hospital, Ridgewood
(Sponsored by N.J. Gastroenterology Society)
 - 3 **Diagnosis of Rhinitis**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
 - 4 **Renal Transplantation**
8:30 a.m. — United Hospitals of Newark
(Sponsored by AMNJ and AAFP)
 - 4 **Community Psychiatry**
11 1:30-2:30 p.m. — Trenton Psychiatric Hospital
 - 18 **Neuroanatomy and Neuropathology**
2:45-3:45 p.m. — Trenton Psychiatric Hospital
Clinical Neurology
4-5 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital)
 - 7 **Immunology**
8 p.m. — Community Memorial Hospital, Toms River
(Sponsored by AMNJ and AAFP)

- 8 **Cortical Steroid Therapy**
8 p.m. — Paul Kimball Hospital, Lakewood
(Sponsored by AMNJ and AAFP)
 - 8 **Clinical Endocrinology**
9 p.m. — Bayonne Hospital
(Sponsored by AMNJ and AAFP)
 - 9 **Obstructive Lung Disease**
1:30 p.m. — Runnells Hospital, Berkeley Heights
(Sponsored by AMNJ and AAFP)
 - 9 **Current Chemotherapy, Breast Cancer**
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
 - 9 **Management of Patients in Diabetic Coma**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
 - 9 **Disorders of Biliary Tract and Pancreas**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
 - 9 **Special Rounds, Obstetrics and Gynecology**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 10 **Perennial Allergic Rhinitis, Vasomotor Rhinitis and Serous Otitis Media**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
 - 15 **Hematology-Diagnosis of Anemia**
12 noon — St. Mary's Hospital, Orange
(Sponsored by AMNJ and AAFP)
 - 16 **Bronchial Asthma**
11:30 a.m.-12:30 p.m. — V.A. Hospital, East Orange
(Sponsored by East Orange V.A. Hospital)
 - 16 **Physical Medicine in Office Practice**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
 - 16 **Special Rounds, General Surgery and Specialties**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 16 **Thyroid Diseases**
1 p.m. — Trenton Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
 - 16 **Current Advances in Cancer Management**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
 - 17 **Drug Therapy of Upper Respiratory Allergy**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
 - 18 **Headache**
12 noon — Freehold Area Hospital
(Sponsored by AMNJ and AAFP)
 - 22 **Echo-Cardiography**
8 p.m. — Warren Hospital, Phillipsburg
(Sponsored by AMNJ and AAFP)
 - 22 **Pacemakers**
12 noon — Hospital Center at Orange
(Sponsored by AMNJ and AAFP)
 - 23 **Current Radiation Therapy, Breast Cancer**
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
 - 23 **Arthritis**
11:30 a.m. — Rahway Hospital
(Sponsored by AMNJ and AAFP)
 - 23 **Neurological Diagnosis**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
 - 23 **Special Rounds, Internal Medicine**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 23 **Virology and Interferon**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
 - 24 **Pediatric Pulmonary Conference**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
 - 25 **Community Psychiatry**
1:30-2:30 p.m. — Trenton Psychiatric Hospital
Psychology
2:45-3:45 p.m. — Trenton Psychiatric Hospital
Forensic Psychiatry
4-5 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital)
 - 30 **Hepatitis**
3 p.m. — Fair Oaks Hospital, Summit
(Sponsored by AMNJ and AAFP)
 - 30 **Aortic Valvular Disease**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital, and AAFP)
 - 30 **Respiratory Virus Infections**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- Apr.
- 1 **Community Psychiatry**
1:30-2:30 p.m. — Trenton Psychiatric Hospital
Psychology
2:45-3:45 p.m. — Trenton Psychiatric Hospital
Forensic Psychiatry
4-5 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital)
 - 1 **Proper Use of Antibiotics**
8:30 a.m. — United Hospitals of Newark
(Sponsored by AMNJ and AAFP)
 - 4 **Orthopedic Problems**
8 p.m. — Community Memorial Hospital, Toms River
(Sponsored by AMNJ and AAFP)
 - 5 **Headache**
11 a.m. — Greystone Park Psychiatric Hospital
(Sponsored by AMNJ and AAFP)

- 6 **Parkinson's Disease and Related Disorders**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
 - 6 **Special Rounds, Pediatrics**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 6 **Selected Topics in Gastroenterology**
8-10 p.m. — St. Michael's Medical Center, Newark
(Sponsored by N.J. Gastroenterology Society)
 - 12 **Collagen Disease**
8 p.m. — Paul Kimball Hospital, Lakewood
(Sponsored by AMNJ and AAFP)
 - 12 **Echo-Cardiography**
9 p.m. — Bayonne Hospital
(Sponsored by AMNJ and AAFP)
 - 13 **Proper Use of Blood Gases**
1 p.m. — Christ Hospital, Jersey City
(Sponsored by AMNJ and AAFP)
 - 13 **Current Surgical Techniques, Breast Cancer**
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
 - 13 **Headache**
11:30 a.m. — Rahway Hospital
(Sponsored by AMNJ and AAFP)
 - 13 **Cardiac Complications of Antidepressant Drugs and Major Tranquilizers**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
 - 13 **Special Rounds, Obstetrics and Gynecology**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 14 **Drug Allergy**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
 - 15 **Community Psychiatry**
22 1:30-2:30 p.m. — Trenton Psychiatric Hospital
Mental Deficiency
2:45-3:45 p.m. — Trenton Psychiatric Hospital
Forensic Psychiatry
4-5 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital)
 - 15 **Scanning**
12 noon — Freehold Area Hospital
(Sponsored by AMNJ and AAFP)
 - 19 **Cardiac Arrhythmias**
12 noon — St. Mary's Hospital, Orange
(Sponsored by AMNJ and AAFP)
 - 20 **Child Abuse and Neglect**
1 p.m. — Trenton Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
 - 20 **Pulmonary Pathology in Connective Tissue Disease**
11:30 a.m.-12:30 p.m. — V.A. Hospital, East Orange
(Sponsored by V.A. Hospital, East Orange)
 - 20 **New Cardiac Drugs**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
 - 20 **Special Rounds, General Surgery and Specialties**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 21 **Insect Allergy**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
 - 26 **Endotoxic Shock**
12 noon — Hospital Center at Orange
(Sponsored by AMNJ and AAFP)
 - 26 **Gastrointestinal Bleeding**
8 p.m. — Warren Hospital, Phillipsburg
(Sponsored by AMNJ and AAFP)
 - 27 **Emotional Crises in Practice**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
 - 27 **Special Rounds, Internal Medicine**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 27 **Lung Cancer**
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
 - 28 **Pediatric Pulmonary Conference and Case Presentations**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
- May
- 2 **Emergency Medicine**
8 p.m. — Community Memorial Hospital, Toms River
(Sponsored by AMNJ and AAFP)
 - 3 **Cerebral-Vascular Disease**
11 a.m. — Greystone Park Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
 - 4 **Thanatology**
1 p.m. — Christ Hospital, Jersey City
(Sponsored by AMNJ and AAFP)
 - 4 **Sports Medicine**
11:30 a.m. — Rahway Hospital
(Sponsored by AMNJ and AAFP)
 - 4 **Low Back Pain**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
 - 4 **Special Rounds, Pediatrics**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 5 **Veterinary Allergy**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)

- 6 Proper Use of Blood Gases
8:30 a.m. — United Hospitals of Newark
(Sponsored by AMNJ and AAFP)
 - 10 Leukemia
8 p.m. — Paul Kimball Hospital, Lakewood
(Sponsored by AMNJ and AAFP)
 - 10 Plastic Surgery
9 p.m. — Bayonne Hospital
(Sponsored by AMNJ and AAFP)
 - 11 Thanatology
1:30 p.m. — Runnells Hospital, Berkeley Heights
(Sponsored by AMNJ and AAFP)
 - 11 Obstructive Lung Disease
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
 - 11 Sputum Examination
11:30 a.m.-12:30 p.m. — V.A. Hospital, East Orange
(Sponsored by East Orange V.A. Hospital)
 - 11 Patient with Advanced Cancer
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
 - 11 Special Rounds, Obstetrics and Gynecology
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 12 Urticaria and Angioedema
11 a.m.-12 noon — United Hospitals of Newark,
(Sponsored by Children's Hospital of Newark and CMDNJ)
 - 17 Tuberculosis
12 noon — St. Mary's Hospital, Orange
(Sponsored by AMNJ and AAFP)
 - 18 What's New in Office Gynecology?
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
 - 18 Special Rounds, General Surgery and Specialties
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 19 Atopic Dermatitis
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
 - 20 Diabetes
12 noon — Freehold Area Hospital
(Sponsored by AMNJ and AAFP)
 - 24 Thanatology
12 noon — Hospital Center at Orange
(Sponsored by AMNJ and AAFP)
 - 24 Bleeding Diseases
8 p.m. — Warren Hospital, Phillipsburg
(Sponsored by AMNJ and AAFP)
 - 25 Proper Use of Blood Gases
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
 - 25 Headache
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
 - 25 Special Rounds, Internal Medicine
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 26 Pediatric Pulmonary Conference and Case Presentations
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
- June
- 1 T.B. — Outpatient Treatment
1 p.m. — Christ Hospital, Jersey City
(Sponsored by AMNJ and AAFP)
 - 1 Special Rounds, Pediatrics
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 3 Psychiatry-Medical Surgical Emergencies
8:30 a.m. — United Hospitals of Newark
(Sponsored by AMNJ and AAFP)
 - 6 Non-Specific Urethritis
8 p.m. — Community Memorial Hospital, Toms River
(Sponsored by AMNJ and AAFP)
 - 7 Arthritis
11 a.m. — Greystone Park Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
 - 8 Special Rounds, Obstetrics and Gynecology
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 8 Endotoxic Shock
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
 - 14 Pacemakers
8 p.m. — Paul Kimball Hospital, Lakewood
(Sponsored by AMNJ and AAFP)
 - 14 Allergy
9 p.m. — Bayonne Hospital
(Sponsored by AMNJ and AAFP)
 - 15 Adult Respiratory Distress Syndrome:
11:30 a.m.-12:30 p.m. — V.A. Hospital, East Orange
(Sponsored by East Orange V.A. Hospital)
 - 15 Special Rounds, General Surgery and Specialties
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 17 Thyroid Diseases
12 noon — Freehold Area Hospital
(Sponsored by AMNJ and AAFP)
 - 21 Hypertension
12 noon — St. Mary's Hospital, Orange
(Sponsored by AMNJ and AAFP)
 - 22 Hemorrhagic Shock
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)

OBITUARIES

Dr. Morton M. Brotman

One of Essex County's senior members, Morton M. Brotman, M.D., died at his home in South Orange on June 2. Born in 1893 and graduated from the University of Maryland School of Medicine in 1914, Dr. Brotman practiced general surgery and industrial medicine in the Newark area for many years. He had been associated with Newark Beth Israel and Presbyterian Hospitals. He retired from active surgical practice in 1952 but continued to maintain an office practice for some time thereafter. Dr. Brotman was a member of the Industrial Medical Association and had been a recipient of MSNJ's Golden Merit Award in 1964.

Dr. Merle B. Davis

At the untimely age of 48, Merle B. Davis, M.D., died on July 18, after a brief illness. A native of Pittsburgh, Dr. Davis received his doctorate in medicine from the Medical College of the University of Virginia in 1951. Following internship he took residencies in obstetrics and gynecology at Harrisburg Hospital (Pennsylvania) and at Cumberland Hospital in Brooklyn, and was board certified in his chosen field. Dr. Davis practiced in Fairmont, West Virginia, until 1960 when he came to New Jersey and transferred his membership in organized medicine to the Middlesex County Medical Society. He was affiliated with both Middlesex General and St. Peter's Hospitals in New Jersey, and was a Fellow of the American College of Obstetrics and Gynecology and a member of the New Jersey Society of Obstetricians and Gynecologists.

Dr. Harold H. Freedman

One of this year's Golden Merit Award laureates, Harold H. Freedman, M.D., died on June 11. A native of New York City, Dr. Freedman received his medical education at the University of Maryland School of Medicine, class of 1926, and came to Freehold for the practice of internal medicine and cardiology. He had been attending cardiologist at Jersey Shore

Medical Center in Neptune and for many years had been medical director of the Monmouth County Welfare Home. He was active in the American Heart Association and its local chapter in Monmouth County. Dr. Freedman served in the medical department of the army during World War II. He was 75 years old at the time of his death.

Dr. Euclid P. Ghee

Word has been received of the death on June 3 of Euclid P. Ghee, M.D., a member of our Hudson County component. A graduate of Harvard School of Medicine in 1927, Dr. Ghee practiced general surgery in his native Jersey City for many years, retiring from full-time practice in 1965. He was a Fellow of the American College of Surgeons and had been on the active staff at Jersey City Medical Center and at Chirst and Community Hospitals there. Dr. Ghee was 76 years old at the time of his death.

Dr. Harold H. Goldberg

Word has been received of the death of Harold H. Goldberg, M.D., in Florida on February 18. One of Essex County's senior members, Dr. Goldberg was graduated from New York University College of Medicine in 1922 and pursued a career in internal medicine with special interest in cardiovascular diseases. He became board certified in that field and was a Fellow of the American College of Physicians. He had been senior attending in the department of internal medicine at Beth Israel Medical Center in Newark and also had staff appointments at West Hudson Hospital in Kearny, Irvington General Hospital, St. Barnabas Medical Center in Livingston, the Essex County Hospital at Belleville, and at the Veterans Administration facility in Lyons. Dr. Goldberg had retired to Florida several years ago; he was 78 years old at the time of his death.

Dr. Alexander A. Introcaso

Alexander A. Introcaso, M.D., a member of our Camden County component, died on June 11 at his home. A graduate of Long Island College of Medicine in 1951, Dr. Introcaso came to Collingswood the following year and established

a practice in general medicine. He was on the staff of the Cooper Medical Center and had served in the U.S. Navy during World War II, prior to his entering medical school. Dr. Introcaso was 53 years old at the time of his death.

Dr. Kwei Lien Kuk

We have just learned of the sudden death, resulting from brain hemorrhage, on May 21, of one of Essex County's newly-elected members, Kwei L. Kuk, M.D. of West Orange. A native of Shanghai, Dr. Kuk received her medical degree from the College of Medicine of National Taiwan University in 1970. She emigrated to Chicago's Cook County Hospital for internship and subsequently took a residency in pediatrics at Martland and United Hospitals of Newark. She was the wife of a West Orange physician, Dr. Chun Kar Hung. Dr. Kuk was only 29 years old at the time of her death.

Dr. David B. Levine

We have just learned of the death on May 17 of David B. Levine, M.D., formerly of Paterson. Born in 1901 and graduated from George Washington University School of Medicine in 1927, Dr. Levine practiced general surgery in the Paterson area for many years. He had taken graduate work at the Mayo Clinic and Mt. Sinai Hospital in New York. Dr. Levine had staff appointments at Barnert Memorial, Paterson General, The Preakness, and St. Joseph's hospitals in Paterson and at Fair Lawn Memorial Hospital. He retired to Hollywood, Florida in 1971. Dr. Levine was a Fellow of the American College of Surgeons and of the International College of Surgeons and had been particularly active in the American Cancer Society, as well as in his local county society which he served as president in the early 1960's.

Dr. Marion J. Makohin

On June 19, Marion J. Makohin, M.D., died at his home after a brief illness. Born in Poland in 1917 and graduated from the Medical College of Friedrich-Alexander University in Erlanger, Germany, in 1950, Dr. Makohin emigrated to the United States in 1959. He served at St. Peter's General Hospital in New Brunswick and at the Jersey City Medical Center and the Tren-

ton Psychiatric Hospital, before establishing private practice in Trenton. He was on the staff in the Department of Internal Medicine at Mercer Medical Center in Trenton and was a member of the Mercer County Medical Society.

Dr. Harry A. Moscoe

Word has just been received of the death on March 17 of Harry A. Moscoe, M.D., an emeritus member of our Passaic County Medical Society, formerly from Paterson. Born in England, Dr. Moscoe received his medical degree from the University of Toronto in 1928 and pursued a residency in psychiatry. He had been attending neuropsychiatrist at Barnert Memorial Hospital and was a member of the New Jersey Neuro-Psychiatric Association. Dr. Moscoe retired to Florida in 1957. He was 73 years old at the time of his death.

Lillian Ponger, M.D.

Word has just been received that Lillian Ponger, M.D., died at her home in Union on April 22nd of acute leukemia. Born in Hungary in 1912, Dr. Ponger was graduated from the University of Budapest Medical School in 1934 and engaged in the practice of anesthesiology. She emigrated to the United States in 1952 and was a member of the house staff at Newark Beth Israel Hospital and later at Overlook Hospital in Summit. She subsequently pursued a residency in psychiatry and became board certified in that specialty. She was associated with the Veterans Administration Hospitals at Lyons and Newark and with Newark Beth Israel Hospital in the department of psychiatry.

Dr. Theodore R. Robie

One of Essex County's well-known psychiatrists, Theodore R. Robie, M.D., of East Orange, died at Mountainside Hospital on May 22 of an apparent heart attack. Born at the turn of the century, Dr. Robie received his medical degree at Yale in 1925 and pursued graduate work in psychiatry and neurology. He was board certified in psychiatry and was a member of the New Jersey and American Psychiatric Associations. He had been on the staff at Mountainside Hospital in Montclair, East Orange General, Presbyterian in Newark and the Veterans Administration

Hospital at Lyons. He was active in medical society affairs and had been a member of the Council on Mental Health for several years.

Dr. Lewis Schwartz

One of Hudson County's senior members, Lewis Schwartz, M.D., of Jersey City, died suddenly on May 5 following a myocardial infarction. He was a general practitioner with special interest in diabetes, and was on the attending staff of the Medical Center, St. Francis, and Pollak hospitals in Jersey City. Born in Austria in 1895, Dr. Schwartz was graduated from Fordham University School of Medicine in 1919. He was a member of the New Jersey and American Diabetes Associations, having been president of the former.

Dr. Armand F. Verga

Armand F. Verga, M.D., of Sea Girt, died on June 12 at Jersey Shore Medical Center from an apparent heart ailment. Born in 1916, and graduated from Hahnemann Medical College in

1940, Dr. Verga practiced internal medicine in the Sea Girt area for many years. He was a member of the American College of Physicians and the American Society of Internal Medicine. He had been on the staff at the Jersey Shore Medical Center for many years and was currently director of the department of medical education there.

Dr. Harry Yolken

One of Passaic County's senior members, Harry Yolken, M.D., of Paterson, died on June 9. Dr. Yolken received his degree in medicine from Washington University in 1932 and took graduate work in pediatrics. He returned to his native city to establish a practice there and was associated with the department of pediatrics at Paterson General Hospital. He was also director of pediatrics at the North Jersey Training School for Mentally Retarded Children. Dr. Yolken was a member of the American Association on Mental Deficiency. He was 69 years of age at the time of his death.

BOOK REVIEWS

Freedom to Die. O. Ruth Russell, Ph.D. New York, Human Science Press (Division of Behavioral Publications), 1975. Reprinted by Dell Publishing, 1976. Pp. 334 (Paperback \$1.95)

The plight of Karen Quinlan has once again generated controversy and medical dissent about the moral and legal aspects of euthanasia. There has been little respite from this problem, since it was only in 1973 that the concerned public in New Jersey was presented with the problem of Lester Zygmanski, who was acquitted of the murder of his brother, rendered quadriplegic in an auto accident.

How timely it is for a highly-specialized text of this nature to become available to those of us who are interested in moral, ethical, and social problems. This book is matter-of-fact, well written, and concise. It is a historical presentation of thought and action on euthanasia from the Greek philosophers to the 1930's, and then decade by decade after that. The author presents opposing views throughout. She also gives an excellent discourse on the role of medicine, plus

official statements from clergy. One chapter is most useful in that it documents current euthanasia legislation and proposals for change.

The book is well indexed and has a useful appendix and bibliography. The physician, whatever his moral and ethical commitments, should read this book to aid him in formulating his own opinions.

Seymour F. Kuvin, M.D.

Current Medical Diagnosis and Treatment. M. A. Krupp, M.D. and Milton J. Chatten, M.D. Los Altos, California, Lange, 1976. Pp. 1,062. (\$14)

A paperback book of 1,062 pages, this publication was "intended to serve the practicing physician as a useful desk reference on widely accepted techniques currently available for medical diagnosis and treatment." Edited by two clinical professors of medicine from Stanford University School of Medicine, the book reads well and has a remarkable wealth of good material prepared by thirty-one coauthors. There are thorough chapters dealing with infectious diseases and antibiotic therapy, as well as chapters organized by a systems approach. The sections on medical genetics, malignant diseases, and immunologic disorders are excellent and would be of particular use for the general practitioner and the general internist. At \$14, the book is a bargain and is recommended highly.

Arthur Krosnick, M.D.

Correlative Neuroanatomy and Functional Neurology. 16th edition. Joseph G. Chusid, M.D. Los Altos, California, Lange, 1976. Pp. 448. Illustrated. (\$10.00 — softback)

This book is indeed a gold mine of information laudably updated. It is concise, well written, and well illustrated. It includes presentation of fundamental material with clear diagrams that included classic reproductions gleaned over the years of sixteen editions from such great workers as Penfield, Bailey, Von Bonin, Krieg, MacClean, and many others.

The work is up to date with precise and concise descriptions of clinical entities and appropriate diagnostic accessory clinical tests, including such recently recognized entities as low-pressure hydrocephalus, the Riley-Day syndrome (familial dysautonomia), and a fairly completely updated pharmacologic armamentarium for the epileptic. The book includes a good, brief dissertation on the proper usages of computerized axial tomography. Designed as an aid to standard neurological texts for the beginner it is a reference source that will be useful on the working book shelves of physicians from family practitioners to board certified neurologists.

Ira S. Ross, M.D.

Stuttering Solved. M. F. Schwartz, Ph.D. Philadelphia, Lippincott, 1976. Pp. 186. (\$7.95)

Most texts on the subject of stuttering are written for the professional speech pathologist. This book is unique in that the author has written in an intimate, conversational style intended for the layman and makes no attempt to disguise either his stuttering theory or its application in pseudo-intellectual jargon. This type of format, while appealing, results in an unnecessary stretching of the "story line," when a more judicious distillation of material could have refined the content, while still preserving its integrity.

In the first two sections of the book, which comprise its major portion, the author deals primarily with the search for and discovery of the physical cause of stuttering and his subsequent development of the airflow therapy. In the third and fourth parts he presents a variety of case studies and specific suggestions directed to parents of stutterers, to the teacher with stuttering children in the classroom, and to the family and friends of adult stutterers.

The exciting contribution that this book makes to the stuttering population and to the speech pathologist is the theory that stuttering has a definite physical component, as well as a psychological one, resulting in a "conditioned laryngospasm" or tensing of the vocal cords which is learned response to stressful situations. However, although the airflow technique purports to be a "revolutionary new treatment," devised in response to the author's theory, it has many similarities to other stuttering rehabilitation programs, in the reviewer's experience, presently being utilized effectively.

The most negative deterrent to initiation of treatment is the author's assertion that the first phase requires an intensive period of therapy — eight hours a day for five full days. Not only is this unrealistic in terms of the average stutterer's expenditure of time, energy and money, but is totally unrealistic in the comprehensive scheduling of both inpatients and outpatients required daily by the speech pathologist in the clinical setting. Although open to controversy, the book is indeed an interesting addition to theoretical concepts on the etiology of stuttering.

Barbara L. Britton, M. Ed.

Heresies. Thomas Szasz. Garden City, New York, Anchor Press/Doubleday, 1976. Pp. 183. (\$2.95 — Paperback).

Heresy means to choose. One who chooses "wrongly," according to the views of a majority, is called a heretic.

Who could be more qualified to write a book of this nature than a heretic, such as Dr. Szasz, who outdid himself in this collection of aphorisms and reflections. It is a stinging, philosophical attack on all sorts of social institutions such as family, marriage, sex, law, medicine, and psychiatry. Although it is very difficult for this reviewer to read such statements as "Doctors control diseases, not persons; psychiatrists control persons, not diseases" without being wounded, Dr. Szasz' statements in other areas are guaranteed to stir the ire of all readers.

This book is exciting, stimulating, and anger-provoking. The reader will be loathe to put it down until it is read through. The value of the book, however, lies in Dr. Szasz' dissent. Even though the vast majority of physicians and psychiatrists will disagree with his views, his heresies are keeping psychiatry and psychoanalysis alive and healthy. Psychiatry will continue to grow as long as there is a Dr. Szasz to prod and challenge. Seymour F. Kuvin, M.D.

Step Right Up. Brooks McNamara. New York, Doubleday, 1976. Pp. 233. Illustrated (\$12.95)

Before radio and television borrowed his techniques and put him out of business, the patent medicine huckster provided entertainment and remedies in the United States and Canada by means of traveling shows and street-corner pitches. In this history, Brooks McNamara, Professor of Drama at New York University, presents an account of these performers and the nostrums they promoted prior to enforcement of the Federal Pure Food and Drug Act.

Medicine shows, which flourished in the late nineteenth and early twentieth century, advertised popular cure-alls in colorful fashion. Pills, potions, salves, and liniments were hawked by extravagant claimers to a credulous public. Such well-known items as Kickapoo Indian Sagwa, Wa-Hoo Bitters, Wizard Oil and Hadacol were vended widely. Today, of course, vitamins and tranquilizers have replaced these panaceas.

Musicians and dancers, sometimes evoking an American Indian or Oriental mystique, were employed to enhance the sale of varied tonics and sedatives. Who can forget W.C. Field's motion-picture peddling of Yack Wee Indian Medical Discovery, Pine Tar remedies, and purple bark sarsaparilla?

The illustrations in this book — handbills, posters, labels, trade cards, and photographs of performers, were culled from far and wide. These now-scarce ephemera help capture the bathos and pathos of earlier times. Various individual performers, troupes, and caravans plied hamlets and towns to provide diversion while selling cathartics, cough syrups, emmenagogues, and vermifuges. Human credulity and hope, exploited by advertising devices worthy of P.T. Barnum or Sammy Slick, made "Toadstool Millionaires" of some manufacturers of familiar remedies. Fraud and quackery often were disguised in bunkum and hard-sell.

Readable and well-documented with notes, bibliography, and index, *Step Right Up* also includes three medicine show scripts, a vaudeville parody, and a glossary of pitchmen's terms. A remarkable trove of pharmaceutical and social lore, this book is of lasting historical value.

Fred B. Rogers, M.D.

Hysterectomy. N. Nugent. New York, Doubleday, 1976. Pp. 181. (\$6.95)

It seems that books about medical subjects for lay readers are of two types — those written by physicians who either write down to a reader or lose him in medical jargon and those attempts by non-physician authors to break down and digest all scientific terminology and regroup it into something a patient can understand, as is tried with this book. In this case the goal is not reached and the book has the worst defect of all — it is dull. To stretch the material Ms. Nugent is forced to resort to "case studies" that are soap operas in print. Your patient can save \$6.95 if she will have you explain the procedure. This, after all, is what we should be doing anyway.

G. F. Hansen, M.D.

Principles of Clinical Electrocardiography. 9th edition. Mervin J. Goldman, M.D. Las Altas, California, Lange, 1976. Pp. 412. Illustrated. (\$9.50)

This book adequately fulfills the author's intention of presenting a volume on the basic concepts of electrocardiography and their clinical applications. There are 412 pages, fully packed with outlines, diagrams, electrocardiogram tracings, as well as explanatory material that renders the subject understandable especially to the doctor who wants to learn the subject from the basics.

The book opens with the usual introduction of electrocardiography, then discusses electrophysiology, vectors, and complexes, after which it enters into the core of the subject which includes hypertrophy patterns, IV conduction defects, myocardial ischemia, myocardial infarctions, and finally cardiac rhythm disorders. The material is presented in a simple, forthright manner without digressing on controversial theories. One very good chapter describes abnormal electrocardiographic patterns in drug effects, electrolyte imbalance, and other complicating conditions. The numerous diagrams and illustrations make the text easy to digest. The author also touches lightly but clearly on topics such as cardiac pacing and spatial vectorcardiography.

The most fruitful chapters are at the end, covering the interpretation of the electrocardiogram and two appendices which review electrocardiographic abnormalities and differential diagnoses of the adult tracing. These latter sections make an excellent quick referral for interpretation.

This book belongs in the library of all medical students, as well as interns, but can also enrich the collection of the practicing generalist. It is the modernized edition (9th) of a standard text that has been used by thousands and withstood the test of time. It looks like the kind of book that will become dog-eared with frequent usage, a comfortable friend not unlike a favored pipe or a well-worn sweater.

Manuel J. Rowen, M.D.

Rachel Weeping For Her Children, Uncomforted. Hazel Lin, M.D. Boston, Branden Press, 1976. Pp. 114. (\$7.95)

None of us can fail to sympathize with the talented young woman who finds difficulty in reconciling her desires for a professional career with her natural feminine instincts. The male physician, in particular, rarely if ever called upon to make such compromises and sacrifices, should understand and respect the problems faced by the female physician try-

ing to be a wife and a mother while seeking to fulfill her responsibilities to her practice. However, such sympathy and compassion is subjected to a severe test of tolerance and patience by the incredible foolishness of the protagonist, Doctor Rachel Lee, who, during her residency in obstetrics, gynecology, and endocrinology, rejects the sincere attentions of her contemporary compatriot, Doctor Ma, and throws herself into the bed of her elderly Caucasian professor without any thought of contraception. Obviously several such careless and irresponsible episodes lead to the inevitable, and the unsatisfactory resolution of the problem created by the prospect of an illegitimate Eurasian baby aggravates a pre-existing emotional disturbance in weeping Rachel.

This novel is so overflowing with all kinds of minute clinical detail and surgical technique, as well as references to suction curettage for abortion and such post-operative phenomena as recovery rooms, sulfa drugs, chemotherapy and radiotherapy, which seem somewhat anachronistic in 1939 China, that the reviewer had even greater cause to wonder why our gynecologic endocrinologist seemed so oblivious to elementary contraception again and again. Possibly unfamiliarity with the English language was responsible for the puerile literary style which failed to create three-dimensional characters that might have transformed an unconvincing plot into a more plausible romance.

It is not possible to recommend this book.

Jerome Abrams, M.D.

Modern Home Dictionary of Medical Words. Morris Fishbein, M.D. New York, Doubleday/Dolphin, 1976. (Paperback—\$1.95)

This Doubleday/Dolphin book, whose subtitle is "How To Understand Your Doctor" is a neat little book, but it will never solve the problem of informed consent. Morris Fishbein, whose name is almost as well known in medical households as "American Medical Association," attempts to reduce to "simple definitions" terms physicians and specialists use in diagnostic as well as routine physical examinations and in those expensive laboratory reports. Unfortunately, he defines complex terms by using other complex terms: "*Lupus erythematosus* . . . a collagen or connective tissue disorder resembling rheumatoid arthritis and scleroderma . . ." Can you see your head-scratching patient asking, "What's connective tissue? Rheumatoid arthritis? Scleroderma?"

I will not discuss the definition of diabetes — an admixture of diabetes mellitus, diabetes insipidus, and fragments of other extraneous disorders — because it hurts my head and causes waves of nausea.

No patient will be able to translate his physician's medical jargonese by quick reference to his "handy dandy home dictionary" while the conversation is in progress. He will, however, be able to get some insight as to the diagnosis on his insurance form or the nature of tests for which he received laboratory charges by reference to Part II. Unfortunately, much of the material — e.g., "conditions diagnosable by amniocentesis" — is much too complex for the average or above-average, non-professional citizen.

Such a book might be useful for medical secretaries, medical record librarians and students in technology, practical nursing and so on.

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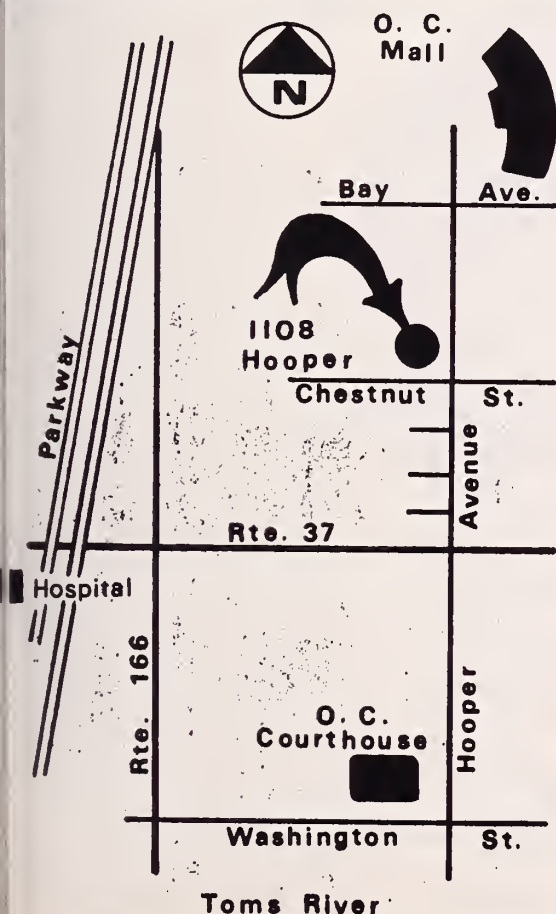
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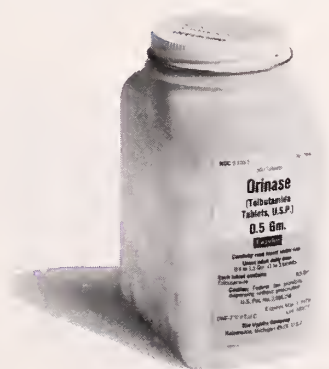
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Published monthly (since 1904), under direction of the Committee on Publication, by The Medical Society of New Jersey, 315 West State St., Trenton, N.J. Printed in Hanover, New Hampshire by the Dartmouth Printing Co. Whole number of issues 866. Member's subscription (\$5) is included in Society dues. Rates for nonmembers, \$10; outside USA add \$4 for postage. Single copies, \$1. Address communications to *The Journal*, MSNJ, P.O. Box 904, Trenton, N.J. 08605 (609) 394-3154. Second class postage paid at Trenton, N.J. and additional entry office. Copyright 1976 by The Medical Society of New Jersey.

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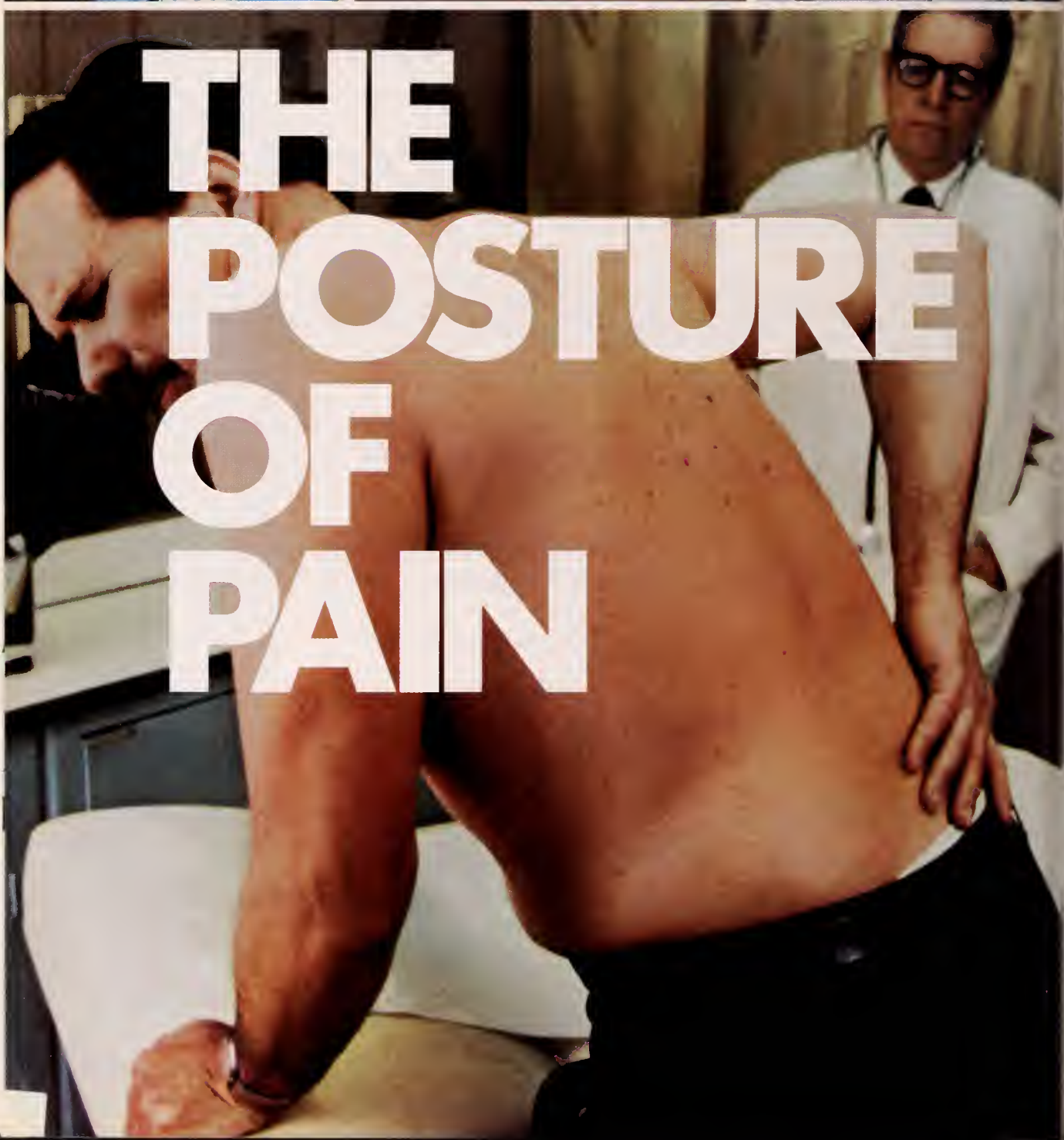
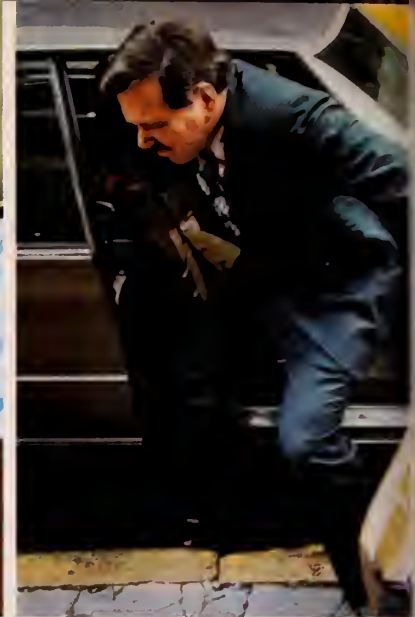
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These usually subside in several hours but supportive and symptomatic therapy, including hospitalization, may be necessary.

Pregnancy and Lactation: Safe use not established; weigh potential benefits against potential hazards in pregnancy, nursing mothers (concentrations in breast milk are two to four times that in plasma), or women of childbearing potential.

Children Under Twelve: Not recommended.

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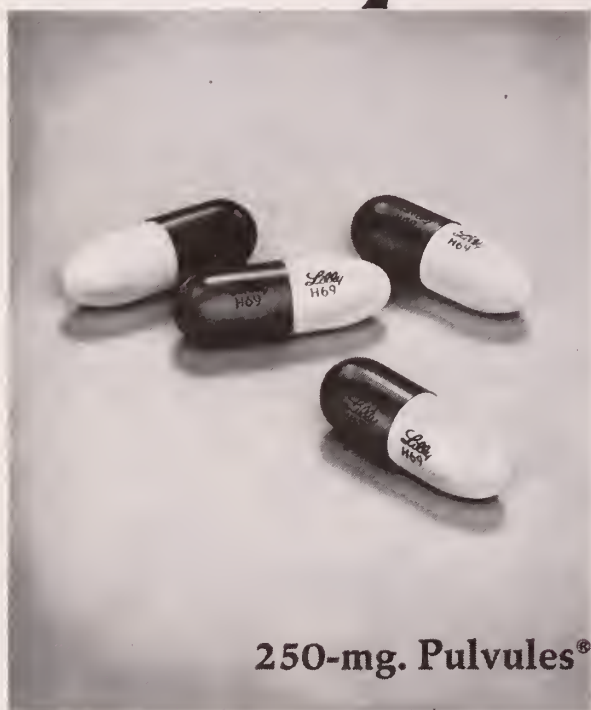
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Usual Adult Dosage: One 350 mg tablet three times daily and at bedtime.

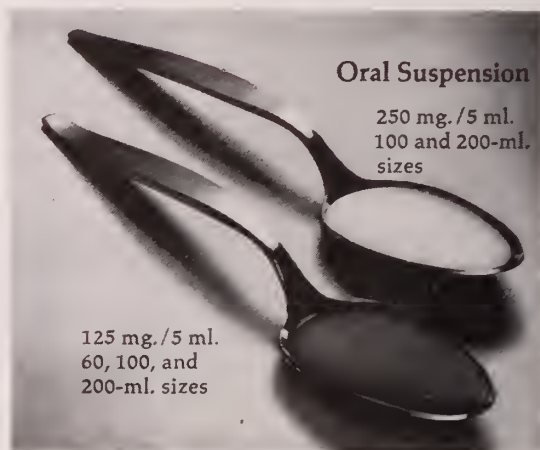
Overdosage: Has produced stupor, coma, shock, respiratory depression, and, very rarely, death. The effects of an overdosage of carisoprodol and alcohol or other CNS depressants or psychotropic agents can be additive even when one of the drugs has been taken in the usual recommended dosage. Empty stomach, treat symptomatically; cautiously give respiratory assistance, CNS stimulants, pressor agents as needed. Carisoprodol is metabolized in the liver and excreted by the kidney. Diuresis and dialysis have been used successfully with related drug meprobamate. Carefully monitor urinary output; avoid overhydration; observe for possible relapse due to incomplete gastric emptying and delayed absorption.

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EDITORIALS

The Mammography Debate

With the present dispute in the scientific literature and the public press over the risks and benefits of routine mammography screening, the primary physician once again finds himself on the "hot seat." The polarization of scientific opinion seems to hinge on the following:

—A study commissioned by the National Cancer Institute (NCI) concluded that no evidence exists to show mammography to be beneficial to "young women" (age 35 to 50).

—The American College of Radiology's Commission on Cancer (ACR) stated that "mammography at appropriate intervals in asymptomatic women over 35 promises to reduce significantly the number of deaths from breast cancer."

The NCI may discontinue screening women below age 50 by mammography in its 27 breast cancer detection centers throughout the country, despite arguments to the contrary by some of the directors of the centers. Meanwhile, the ACR recommends that asymptomatic women should have their first (or baseline) mammographic study between the ages of 35 and 40, and re-examination at least every one to three years.

In a cooperative breast screening study by university centers to determine *yield* versus *morbidity* and *expense*, 45 percent of asymptomatic patients with positive mammograms did *not* have clinically suspected disease.¹

The question of "benefit" is juxtaposed with the issue of "risk," i.e., is there a hazard from radiation from mammography? The potential for harm refers to the possibility of mammography itself causing breast cancer through a direct carcinogenic effect. The quoted evidence here relates to studies of (1) women exposed to radiation from atomic bombs at Hiroshima and Nagasaki,² (2) women exposed to x-ray and

fluoroscopy of the chest during treatment of pulmonary tuberculosis,³ and (3) women treated by radiation for mastitis.

Thus, the physician who recommends to his 35-year-old female patient that she have routine mammography screening has a problem. If he follows the ACR advice, his patient will have anywhere from six to sixteen studies prior to age 50, an age period when the NCI implies that *none* should be done!

This is not the end to his problem. One of the so-called indications for mammography that a breast cancer screening network uses is: "patients with cancerophobia who are felt to require reassurance through mammography." Since the patient afflicted with a deep-seated fear of cancer is almost never reassured by a single x-ray study or a single physical or laboratory examination, the performance of x-ray mammography as a psychotherapeutic measure seems counterproductive.

Breast cancer appears to start mainly in the 50-year-old age group, with less than one percent occurrence in patients under the age of 35. Aside from the low yield, one problem with x-ray mammography in the under-35-year age group is the danger of a false negative study of the dense breast tissue of the young. In older women, deposition of fat in the breast permits better delineation of structural aberrations and offers the radiologist a better opportunity to recognize a tumor.

In the final analysis, as usual, the primary physician must use his own reasoning powers to establish a policy when the "experts" disagree. In relation to x-ray mammography he might consider the following:

1. Proper performance and interpretation of x-ray mammography is an effective tool in the detection of breast cancer.

2. Despite the unsettled question of radiation-induced carcinogenesis, present low-level radiation exposure through mammography appears safe when the procedure is performed properly. It certainly does not compare to the Hiroshima-Nagasaki situation, where women were exposed to 100 to 200 rads of radiation to the anterior chest wall.²

3. Asymptomatic women under age 35 (like all women) should have annual physical examination of the breasts and should be taught breast self-examination.

4. Women at high risk for breast cancer — especially those in the 45 to 50 and older age group — should have the benefit of x-ray mammography in addition to careful physical examination. High-risk factors include a family history of breast cancer (mother or sister) or a personal history of endometrial carcinoma.

5. Patients who are difficult to evaluate due to fibrocystic disease or nodular or large breasts should also have x-ray mammography.

6. Obviously, patients with such specific problems as a palpable mass or breast symptoms, including pain or a nipple discharge, should have x-ray mammography.

7. Cancerophobic females, who are not in the high-risk group for breast cancer, might benefit more from psychotherapy coupled with a physical examination and an innocuous procedure such as thermography which may be repeated without risk. If she is in the high-risk group, one has no choice but to study the cancerophobic female by all appropriate means.

In summary, each physician should have his own policy for the use of x-ray mammography for his patients. At the very least, he should be familiar enough with the subject to use x-ray mammography selectively for high-risk individuals at any age, if not for routine screening of asymptomatic females greater than 35 years of age.

A.K.

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¹Feig S and Levine RB: Unpublished communication. Thomas Jefferson Medical College and American Oncologic Hospital, Philadelphia, 1976.

²Wanebo CK, Johnson KG, Sato K, and Thorslund TW: Breast cancer after exposure to the atomic bombing of Hiroshima and Nagasaki. *N Engl J Med* 279:667-671, 1968.

³Myrden JA and Hiltz JE: Breast cancer following multiple fluoroscopies during artificial pneumothorax treatment for pulmonary tuberculosis. *Can Med Assoc J* 100:1032-1034, 1969.

Sacrifice the Best Players?

In pre-Columbian America, the Mayas and the Aztecs played a sacred ballgame on a field which measured 309 feet long and 114 feet wide and which was flanked by two twenty-six foot high walls. At the center of the field, a large stone ring was positioned near the top of each wall. Two teams of seven well-padded players vied to make a rubber ball pass through the stone rings by butting it with head, shoulders, knees, hips, or elbows. It was forbidden to hit the ball with

hands or feet, or to let the ball touch the ground. The extreme height and angle of the ring made it nearly impossible to clear this vertical "basket," so winning or losing apparently was decided according to which team committed the smaller number of errors.

Bas-relief on the walls of the ballfield terrace make it clear that the captain of one of the teams — most believe the losing team — was decapitated as the culmination of a "liturgical function," which was the major purpose of this experience. Some, albeit a minority, argue that the captain of the winning team was "rewarded" by being separated from his head and allowed to report forthwith to his gods. In either case, the loss to the community was not small since the players were obviously superior men.

This kind of strange behavior — contrasted with the six and seven-figure contracts awarded to modern professional football, basketball, baseball, and tennis players — seems bizarre as we look back over the past 17 centuries. This ancient Mayan civilization was obsessed with time, with complex calendars, and with astronomy and mathematics. Yet, they sacrificed some of their best citizens on the basis of a ballgame.

If one could translocate himself 17 centuries from now, and look back at our civilization, would he recognize comparably whimsical behavior? The small and large "wars of liberation," the political assassinations, the German holocaust of World War II, the kidnappings, and the intra-family murders all would be major anti-human deeds to evaluate. There are less formidable but nevertheless equally bewildering "atrocities" of a different type which might be considered.

The fact that many of our most highly-trained, extremely skilled, dedicated, tireless, and courageous physicians have been singled out for "punishment" by the very people who have sought out their help and skills is astounding today and will be more so in the future. The record shows that there is a malpractice claim for every 1.2 neurosurgeons, one claim for each 2.1 orthopedic surgeons, and one claim for each 4.6 anesthesiologists and surgical specialists. What can this mean? That these men and women are

poorly trained and practice poor medicine and surgery? Their credentials and peer review easily can discredit this hypothesis.

We must assume that there is a litigious public who is ready to sacrifice the best players — with the assistance and encouragement of certain legal advisors — for alleged wrongdoing, often based on unrealistic expectations. This outrageous situation has driven some excellent practitioners into retirement and has distorted the idealism of most physicians.

We don't know whether the best practitioners of medicine and surgery will withstand the pressures of this threat until a reasonable public, a wise legal profession, and a responsible legislature decide that they will all lose the most in the end if something reasonable is not done. All we can do is hope that they can. A.K.

Support the Academy of Scholars

There is hardly a physician in New Jersey who has not gained or cannot benefit from the activities of the Academy of Medicine of New Jersey. The pressure to participate in continuing medical education programs for purposes of accreditation and possibly for recertification has made us all sensitive to our own needs in this regard. The Academy, like a comfortable pair of shoes, is often taken for granted by the individuals who benefit most from its services.

The immediate past-Editor of *The Journal*, the late Henry A. Davidson, M.D., described the scene on the occasion of the founding of the Academy as follows:

"It was one cold, wintry night on February 25, 1911, that some determined, dedicated, knowledge-thirsty doctors came streaming into the (Newark) public library, some walking across Washington Park from the fashionable houses that, in those days, were located in the downtown section of Newark. Some came on bicycles, some in buggies, and some chugged along Washington Street in high-fendered, open-top automobiles. They came from Newark and Jersey City, Hilton and Communipaw, Elizabeth and Vailsburg. By ten o'clock there were nearly a hundred of them, crowded into a shelf-lined corner, perched on chairs and stools and book-boxes, eager to give the breath of life to the age-old idea of an Academy of Scholars."

The "breath of life" has been fostered over the past 65 years, during which time frame the Academy has grown in stature and eminence. Its academic accomplishments have flourished since 1972 when reasonably accurate attendance and sponsorship records were first kept. It was that year that the Academy was approved by the AMA as a Category I, CME-granting institution. The number of accredited symposia (roving symposia, major symposia, scientific section meetings, and cosponsored meetings) has nearly quadrupled from 300 in the academic year 1972-1973 to 1100 in 1975-1976. During the same interval attendance grew tenfold — from 8,000 to 80,000. The Academy also received accrediting powers for dental meetings from the Academy of General Dentistry in 1974.

In addition to accreditation, the Academy serves community hospitals by providing a review of and publicity on their major continuing medical education activities. The Academy's monthly program, which goes to the fellowship and its monthly calendar, which goes to all hospitals, as well as to this *Journal*, makes it easy for physicians to remain current.

As its founders had hoped, many other scholarly functions are provided. There is a speaker's bureau. Through the library, recently merged with the library of the College of Medicine and Dentistry of New Jersey in Newark, its membership is eligible to make use of such resources as research, bibliographies, reference lists, photo-duplication, and numerous other functions of a full-service medical library.

Although the Academy's roster has grown by 400 new members in the last three years, only a small fraction of The Medical Society of New Jersey membership has joined that august and scholarly body. Lest the "breath of life" which started this "Academy of Scholars," become obstructed by lack of interest and support, all physicians are urged to join the Academy of Medicine of New Jersey. Since physicians are — and always have been — scholars, they should belong to, as well as participate in the activities of the Academy.* A.K.

*The Academy is located at 2424 Morris Avenue, Union, New Jersey 07083.

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* **WRITE FOR REPRINT:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioğlu, M.D.: Hormones for Improved Sexuality in the Male and Female Climacteric, *Drug Therapy*, Sept. 1976.

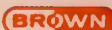
Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25

(methyltestosterone 25 mg.), on 20 males, 50 years of age or older who complained of secondary impotence. Patients received a series of placebo then Android-25, or Android-25 then placebo as follows: 1 tablet/30 days; 2 tablets/30 days; 3 tablets/30 days. Sexual response was evaluated: 0 = no change; + = 25% improvement; ++ = 50% improvement; +++ = 75% improvement. Placebo effectiveness was + or ++ in 12.7% of trials. Android-25 elicited a +, ++ or +++ response in 47.2% of trials. There was often a dose related response not observed with the placebo. This effect was not observed in younger patients (age 28-45 years).

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avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpubertal cryptorchidism, 30 mg. **REFERENCE:** Robert B. Greenblatt, M.D., and D. H. Perez, M.D.: "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.



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Two comprehensive health centers, one based in a university hospital and the other a satellite based in the community but staffed by university health personnel, have operated for a period of three years, carrying out health screening and delivering primary health care to over 1,500 families. The various strengths and weaknesses of such a program are explored, the types of health problems encountered are defined, and the most valuable screening and health care activities enunciated. These include dental care, nutritional guidance, hypertension and lipid screening and treatment, prenatal, gynecologic, and family planning services, acute illness care, including 24 hour emergency service, outreach and education, and hospital backup for ambulatory and laboratory services and for in-patient care.

The Newark, New Jersey, Neighborhood Health Center Project†

**Allyn P. Kidwell, M.D.,
Waymon C. Lattimore, M.D.,
James Foster, B.S., and
Donald B. Louria, M.D., Newark**

Beginning in September 1970, the New Jersey Medical School opened the Newark, New Jersey, Neighborhood Health Center Program, assisted by State and Federal grants.* There were two health centers established, one based in the outpatient department of the College's principal teaching hospital, and the other, a satellite unit, located in a community-operated project that housed several additional service programs. In the case of the first center, the goal was to convert the hospital outpatient department to a comprehensive, family-oriented, neighborhood health center, whereas the new satellite center was to provide such care from its inception.

Due to restrictions in space, staff, and funding, the hospital center was limited to 300 families and the satellite to 1,000 families in this pilot study. Each center had its target area from which to recruit and register patients and registration to the saturation point occurred quite rapidly.

Both centers used the same hospital, laboratory, x-ray, emergency room, and other facilities. Both used similar record systems, and to some extent, the same physicians. A standard disease-detecting protocol was established prospectively and was adhered to reasonably well. The purpose of this paper is to define and describe en-

titles encountered in this population during a two-year period, and to make some observations on the health care systems employed. These data are useful in the planning of such facilities assuming that one major purpose is rendering care with a relatively low cost:benefit ratio.

The Population and the City

Newark, a city of 380,000, is in precarious health politically, fiscally, and medically,^{1,2} the latter in spite of the fact that it has a young population with a median age of 25 years. The aggregate death rate is 35 percent above the corrected national standard, while the infant mortality rate here ranged in recent years from 26 to 40 per 1,000 live births, as contrasted to a national rate of approximately 18/1000. The incidence of gonorrhea was 1446/100,000 in Newark in 1974, compared to an average of 826/100,000 in major U.S. cities. Comparable figures for primary or secondary syphilis are 88/100,000, contrasted to 12/100,000. Tuberculosis incidence is 70/100,000 while the national figure is 17/100,000. Drug abuse is rampant and lead poisoning widespread. This city is in or near the forefront in drug abuse, lead poisoning, tuberculosis, and venereal disease.

The health providers in Newark have dwindled. Three major hospitals have left the city in ten

†This study is from the Department of Preventive Medicine and Community Health, New Jersey Medical School, CMDNJ, Newark.

*Office of Economic Opportunity, Grant #20508; New Jersey State Department of Health, Grant #k287.

years. The four major hospitals remaining incurred losses in excess of \$13,700,000 in 1971. In the fifteen years, 1955-1970, the number of physicians in Newark was halved. In the period 1962 to 1970, dentists experienced an attrition rate of nearly 30 percent. More than one-third of available housing has been rated substandard. The total population has decreased from 405,000 in 1960 to 380,000 in 1970 while the percentage of blacks has risen to 56 percent. Approximately 30 percent of the residents are receiving categorical assistance and median annual family income in the inner city is \$5,883. The overall unemployment rate is 16 percent while that for males aged 16-25 is over 30 percent. In spite of millions of dollars of federal and state aid and a rising property tax rate that has contributed to the exodus of many businesses, the city is on the verge of bankruptcy. Overshadowed by nearby New York City, it is considered inadequate in terms of social, cultural, economic, residential, educational, and health standards and values.

An estimated 147,000 residents have some access to private health insurance, principally Blue Cross; 110,000 are eligible for New Jersey's categorical Medicaid program; and approximately 30,000 have Medicare. Thus 100,000 persons have no health insurance of any kind and of those that do, most have no coverage for ambulatory or preventive care.²

The Protocol for Health Care and Screening

Health services at each center were dispensed by a team consisting of an internist, a pediatrician, a dentist, a gynecologist, a family health worker, a health educator, a social worker and a nutritionist — all for care within the Center — and by a public health nurse coordinator and four to six additional community family health workers for outreach work.

Transportation for patients and records was provided by the satellite center. The patients paid no fees for services, although responsible third party carriers were billed. Prescription medications were also supplied without cost to the patient.

The families entering into this program were enrolled from the hospital wards and clinics, or,

in the case of the satellite center, from its other social programs. Active recruitment from the target community was also utilized by both centers. The family health workers played a crucial role in recruitment. They identified problem patients from the outpatient department or from the community who needed special services. They interviewed new families in their homes, often completing the health history questionnaire there, and then making appointments. If the appointments were not kept, the family health workers would telephone, or return to those homes without phones, to establish new appointments. They also rendered rudimentary home care, or arranged for home visits by the public health nurse and/or the physician; they visited their patients when they were hospitalized, accompanied them to specialty clinics when they were referred and served as ombudsmen to their patients. Since they were from the community themselves, they often knew factors concerning a patient's illness or social situation that might not otherwise have come to the attention of the physicians.

Once any family member was registered, an effort was made to recruit the balance of the family for routine examination. Although most of the families were large, often with the mother as the head of the household, and with children outnumbering adults 3:1, much of the child care was routine or for short-term illness. For convenience this paper is focused on adult health problems.

The protocol called for each adult to have a health-history questionnaire for older events, a direct interview by a physician for current illness and a physical examination by the physician. Most of the physical examinations in both centers were done by two internists, although some prenatal patients were examined exclusively by obstetricians. Blood pressures were measured by physicians, who accepted 150/95 mm. Hg. as the upper limit of normal for screening purposes.

Laboratory tests included complete blood count, sedimentation rate, urinalysis, Sickledex®, serology, blood urea nitrogen, fasting blood sugar, electrolytes, cholesterol, and triglycerides. Chest x-ray was routine, as was a Papani-

colaou (Pap) smear for women over 18 years. Electrocardiograms were done for men over 35 and women over 40. Intermediate PPD (5 tuberculin units) skin tests were done on the adults at the satellite center, but not at the hospital center. Stool examinations for ova and parasites were performed at the hospital center on all patients from southern United States or Puerto Rico. Over and above screening, all patients could have a further outpatient or inpatient workup at the discretion of the physician.

Not every patient who registered completed this investigation. Some registered but never presented themselves for any clinical services; others came for episodic or partial care only. There were many reasons for this: (1) patient attitudes and inertia; (2) failure to understand or keep appointments; (3) poor paramedical staff performance³ on such administrative tasks as establishing appointments, recalling patients, filing records, generating laboratory, x-ray, and other reports, or the active seeking of such missing reports; and (4) physician oversight, such as failing to record a blood pressure, to complete a progress note, or to specify a return appointment. Many medical records were excluded from this survey because of inadequacies. For inclusion, adequate screening was defined as the completion of the medical history, physical examination, and all laboratory reports except any random two. For the purposes of these data, even a single abnormal observation filed in the record may have been accepted as a "diagnosis" even if it were never corroborated by a return visit. Thus a solitary elevated blood pressure recording or weight measurement is included here as "hypertension" or "obesity." Dental or periodontal disease observed by the physician, even if not corroborated by the dentist, is likewise included as a diagnosis. It is recognized that in the case of the elevated blood pressure a repeat determination might have been normal, and conversely that complete dental examination of all mouths would have revealed a higher incidence of dental disease. In the case of laboratory values, in spite of a system devised and taught to the staff for the identification of abnormals, many such were not followed up. This was particularly true in the case of lipid screening (cholesterol and triglycerides), an unfamiliar procedure for staff and patients alike,

who interpreted it initially as "experimental," and only gradually came to recognize its value and importance.

Results

In all, 345 adults were included as adequately "screened" in the outpatient unit, while 1026 were screened in the satellite center. The patients were all over twelve years of age, and were divided into categories by age and sex (see Table 1).

Table I
Patients Distribution by Age, Sex and Health Center

Age	Males		Females	
	Hospital Unit	Satellite Unit	Hospital Unit	Satellite Unit
12-19	44	87	62	159
20-29	22	46	60	203
30-39	18	40	64	160
40-49	13	22	34	78
50-59	7	12	12	52
60-69	3	20	4	56
70-79		24	1	41
80-89		4	1	19
90-99		1		2
TOTALS	107	256	238	770

In both centers, females over 21 years predominated, confirming a generally understood trend of utilization of health facilities by adults.

A tabulation of the most common diagnoses encountered at both centers, in order of frequency, is shown in Table II. Of necessity some categories are broad such as "gastro-intestinal" and "cancer," or "gynecological" and "venereal disease."

Assignment was made to one group only in such cases, perhaps arbitrarily. It is also obvious that many of these patients had multiple diagnoses, and since all are tabulated, the total number of diagnoses far exceeds the total number of patients. This is true even though the patients in whom no abnormalities were found, a lamentably small number, are also included in the totals.

The most common disorder of all found was dental or periodontal disease. The most frequently encountered medical problems included obesity, various gynecologic diseases, hypertension, hyperlipoproteinemia, pregnancy, der-

Table II
Numbers of Abnormalities Identified

	Hospital-based Health Center		Satellite Health Center	
	Numbers	Percent	Numbers	Percent
Dental disorders	98	28	Not cataloged	
Obesity	91	26	188	18
Parasitism: morbid	20	7	7	1
non-morbid	5			
Pregnancy	37	11	94	9
Hyperlipoproteinemias: Type II	3	10	Not cataloged	
Type IV	32		Not cataloged	
Dermatoses	30	9	44	4
Anemias	28	8	28	3
Gynecologic disorders	26	7	202	20
(including gonorrhea)				
Normal	25	7	Not cataloged	6
Hypertension (all types)	19	5	154	15
Urinary tract infection	14	4	20	2
Gastro-intestinal disorders	14	4	50	5
Diabetes mellitus	13	4	57	6
Arthritis (all types)	13	4	104	10
Asthma	12	3	22	2
Old skeletal trauma w/deformity	10	3	Not cataloged	
Psychosomatic disorders	9	3	54	5
Syphilis (all stages)	9	3	6	1
Headache (non-specific)	9	3	Not cataloged	
Tuberculosis (all stages)	9	3	27	3
Arteriosclerosis (all stages)	11	3	38	4
Hemoglobin AS	8	3		
Emphysema, bronchitis	8	3	4	1
Seizure disorder (all types)	7	2	12	1
Gout	2	1	4	1
Sarcoidosis	1	1	2	1
Hepatitis	4	1	4	1
Neoplasia (all varieties)	0	0	4	1
Gonorrhea (male)	1	1	38	4
Miscellaneous, significant disorders	19	5	34	3
Total	345		1026	

matoses, and arthritis. Somewhat contrarily, diabetes mellitus, tuberculosis, venereal disease, and sickle disease or trait were uncommon in this group.

The results of certain screening procedures deserve special emphasis. Screening for hemoglobinopathy A-S or S-S has been mandated by public demand to the extent that the same individual may be screened in schools, health clinics, walk-in facilities, health fairs, and other "health drives," even though the medical merit of this procedure has been questioned,^{4,5} and the only preventive measure as yet available is genetic counselling, which frequently is not acceptable to the same vocal, affected population. In this study, only three percent of adults had hemoglobin A-S, and none had S-C or S-S.

Although most patients had at least one chest x-ray, not a single case of active pulmonary tuberculosis was detected in this survey. One new case of tuberculosis of the spine was found, but the diagnosis did not result from the preliminary screening. Numerous positive tuberculin tests in asymptomatic adults with negative chest x-rays were recorded in a special study subgroup at the satellite center, and these received prophylactic isonicotinic acid hydrazide therapy for one year. Chest x-rays did identify another ten abnormal patients, eight with asymptomatic pulmonary fibrosis, scarring and emphysema of unknown cause; one patient had an asymptomatic collapsed, infected, right middle lobe which subsequently was resected, and another had sarcoid disease which subsequently was confirmed by liver biopsy.

In another subgroup, made up of Puerto Rican immigrants and southern United States migrants who visited the hospital-based center, a single stool specimen was examined for ova and parasites. Although the protocol called for all such patients to have at least one stool examination only 79 of 134 actually had one, illustrating the problem of compliance and follow-up. Of the 79 patients screened, 43 parasites were identified in 25 patients. Only five of 25 had non-morbid infestation, while 20 were infected with combinations of *Strongyloides Stercoralis*, hookworm, *Ascaris Lumbricoides*, *Schistosoma Mansoni*, *Trichuris Trichiura*, *Entamoeba Histolytica*, and *Giardia Lamblia*. The population of the satellite center contained a very small at-risk population and was not screened. Nonetheless, seven cases of parasitic infestation were recorded.

Discussion

It is not surprising that the two most common problems encountered were obesity and dental/periodontal disease. With respect to the dental disorders, this is particularly significant in this series in that the principal funding agency made no budgetary allocation for dental care. Even in the face of these statistics, the response was that funds might be made available for the children, because something preventive might be achieved, but that it was too late to be concerned about the adults. This paradox eloquently illustrates the inherent problems of delegating to non-professionals the task of planning health services and controlling the funds. Clearly, the accepted preventive in the children should be the fluoridation of the drinking water, which is not now done in Newark. For adults, restorative and prophylactic dental management is mandatory.

Obesity is well known to constitute a major health problem among the poor.^{6,7} It is related to many factors including societal practices and beliefs, inadequate nutritional education, economics, and psychological attitudes. It is also notoriously resistant to treatment and to education. No drug therapy was offered to this group, but a trained nutritionist was always available. Most patients made no more than two visits to see her, and many broke appointments. Not a single patient in this series realized a sustained or successful weight reduction, including

employees of the program who were also registered as patients.

Hypertension is widely held to be a health problem of significant magnitude in poor blacks,⁸ yet its incidence was somewhat low in this group. Perhaps this was related to the generally lower average age in the city as a whole, and in this group in particular. The family health workers were not utilized for outreach screening for hypertension, which undoubtedly would have increased the case detection rate. The success of this approach elsewhere⁹ plus the now undisputed value of the early treatment of asymptomatic essential hypertension^{10,11} mandates further efforts in this realm and will constitute an important goal for this program in the future. Although all hypertensive patients in this group had further investigations and treatment at the discretion of the attending physician, follow-up was poor, as reported by others.⁹

Diabetes, usually common in this population, proved not to be so in this study group. This may be a reflection of both the relatively young age of the group and of the arbitrary choice of employing a single fasting blood sugar level over 125 mgm. per 100 ml. as a basis for preliminary, or screening, diagnosis. In establishing the initial protocol, it was acknowledged that while utilizing a two-hour post-prandial blood sample would have potentially diagnosed more mild diabetics, it would also have rendered the blood lipid studies invalid. It was further anticipated that multiple blood samplings would have resulted in poorer patient compliance with the screening, a conjecture that was proved correct by the large numbers of patients who never returned for even a single blood sampling. The anticipated difficulties of timing a two-hour postprandial test were also ultimately confirmed by the data on poor patient cooperation in keeping appointments. Finally, it was felt that since control of hyperglycemia is the only universally accepted goal of diabetic therapy, and that prevention of so-called "late complications" is still conjectural,¹² limiting the screening process to detecting overt diabetics was a realistic, if not ideal, goal. Within these limitations, very few cases of previously undetected diabetes mellitus were uncovered.

Of the other disorders in which laboratory screening played a crucial role, the hyperlipoproteinemias and anemias deserve mention. The ready accessibility of a laboratory engaged in a prevalence study of hyperlipoproteinemias was a valuable asset, and once the blood test was accepted by staff and patients alike, the screening yield was significant. Many registered patients never received the test, and some of the positives were not confirmed on retesting with more vigorous adherence to fasting conditions. Identified patients were referred to a special lipid clinic for additional work-up and treatment.

Anemia was present in 3 percent of the study group. Most anemia proved to be simple iron deficiency in women of child-bearing age. No sickle cell disease was identified by blood count alone, and no unsuspected neoplasia or other occult disease presented as unsuspected or unexplained anemia. Laboratory screening was the only clue to the diagnosis of anemia in this series and its value is clear.

Other laboratory screening procedures proved unproductive, however. No new cases of secondary or tertiary syphilis were identified. Of eight positive serologies in the hospital-based center, one was a biologic false-positive, six were in Wasserman-fast adequately treated cases, and one was considered latent syphilis and was treated. In spite of this misleadingly low yield, it would be unthinkable to omit a serologic test for syphilis from a screening program in a city which nationally is one of the leaders in venereal disease.

Obstetrics and gynecology were included in the program, not as part of screening per se, but because the prevalence of disorders in this category in this population merited it. The low incidence of gynecologic cancer has already been commented upon. Patients registered in this program received advice and services in family planning in a parallel program, again with a high demand.

Specialty services not directly included in this program, but essential and accessible, listed in order of frequency of referral, were ophthalmology, dermatology, gastroenterology, ortho-

pedic surgery and psychiatry. Contrary to expectations, the latter was little used. This may have been due to a low index of suspicion on the part of referring physicians within the program, reluctance by the patients, or to the fact that the available Community Mental Health Program was in its nascent stages and not really available. Overt psychoses were few, although anxieties and tensions related to inner city life are well known, and requests for tranquilizers were frequent. Referrals to ophthalmology were based on patient request or complaints in the history, rather than on screening, and were commonplace. Nevertheless, not a single case of glaucoma or other insidious eye disease was detected. Refractive errors, of course, were the major problem identified.

All other specialties were utilized to only a very small extent. Cardiology referrals were infrequent, partly because few cardiac problems were identified, but also because the internists within the program elected to treat most of them. Urinary problems were screened for only by history, urinalysis, and BUN. Routine cultures and colony counts were not attempted due to difficulties of collection, but simplified procedures might be worthwhile.¹³ Nevertheless, few urinary problems were identified; those that were had additional evaluation and treatment.

Comments

The merit in assessing these data lies in their utilization in the planning of future health care delivery efforts and in suitable allocation of funds. While "screening" has been variously defined, its value both lauded^{14,15,16} and derogated^{17,18} and its true worth yet waiting definition, it is still an axiom of preventive medicine that early detection of certain disorders, at our present state of knowledge, is the only technique of value in the prevention of their progression and dissemination. Furthermore, data on cost effectiveness are meager and in spite of their lack, some items will be included in screening programs for reasons other than cost or effectiveness. For example, few would dispute the desirability of Papanicolaou smears, yet in this survey only one Pap smear was positive, and that was in a woman who ultimately proved not to have carcinoma. The cost of Pap smears was

\$4,000. Conversely, the one case of cervical carcinoma detected from all women examined had several false negative Pap smears.

Many screening programs have foundered because of poor coordination with treatment facilities¹⁷. While the screening technique suffered here because of lapses in the conduct of the testing protocol, an obstacle overcome elsewhere by better patient flow, record keeping, and coordination¹⁶, the follow-through on treatment was good. Not a single serious entity tentatively identified by screening escaped further work-up or treatment except when the patient refused care. Of great importance was the fact that the same physicians responsible for the screening were equally responsible for the treatment, for referral to specialty services, or for hospitalization in an institution in which they held both staff membership and faculty appointment. This arrangement successfully bridged the gap in back-up services and smoothness of patient flow that has beset many similar enterprises.

Clearly it would be impossible to predicate an adequate screening program on a small experience in one city, but several needs stand out from this study. First, screening and therapy are inseparable and should include, at a minimum, medical and dental care, nutritional programs including diet counseling, and screening for anemia, hypertension and hyperlipoproteinemia, problems in obstetrics and gynecology, dermatology, and for parasitic disease for the at-risk population. Outreach and health education, and back-up services from hospital, specialty clinics, and emergency room are necessary.

Second, adequate planning cannot be conducted without health-impact data such as these. OEO officials disclaimed any interest whatever in evaluating these parameters¹⁹ and concentrated only on patient-flow and cost data.²⁰ This myopic approach led them to defund this health care program in one of the sickest cities in the United States, a fact that defies comprehension and mandates more responsible professional, rather than political, participation in health care planning and funding.

Third, the oft-repeated myth that access to

health care is denied millions of Americans largely because of financial barriers is not borne out by this patient group. Although no fees were charged, the fact that many registered patients never availed themselves of services — 40 percent of all appointments were broken — and treatment recommendations were often ignored, serves as a warning to those who would rely solely on a system of national health care financing as a panacea.³ Clearly, other motivation to encourage the public properly to utilize a health care system is mandatory. Health education may be part of the answer, but as yet there is little evidence to support this contention. This is eloquently exemplified by the continued widespread practice of cigarette smoking, the incidence of such health problems as obesity, alcoholism, drug addiction, and unwanted pregnancy, and by the large numbers of American women who have never had a single Pap smear in their entire life.

Fourth, medical care in this milieu is very inefficient and therefore, unnecessarily costly.²¹ Personnel training programs are expensive and the employment opportunities offered in such a setting are traditionally low-paying. Thus, those employees who receive training move out to better surroundings and jobs as quickly as possible, leaving the less motivated to accrue seniority in the inner city setting. This leads to: (1) poor attitudes towards the job and the patient; (2) inadequate clerical services such as appointment and message receiving, x-ray and record filing, report generating, and data collection and processing; (3) lateness and absenteeism; (4) waste due to broken appointments, repetition of lost x-rays and lab tests, and poor coordination of health services among the multiple categorical programs usually offered to residents of such an area; (5) poor billing practices arising out of inadequate or inaccurate fiscal and demographic data and from the multitude of third party carriers, each with its special reporting demands; and a host of inextricably related issues that have been detailed by other observers.³

Finally, health care is only a portion of the total spectrum of ills that beset an area such as Newark. Poverty is a vicious cycle including poor housing, inadequate education, limited job

opportunities, unstable family relations and insufficient "home enrichment," poor sanitation, deficient nutrition, attitudes of despair, depression, hostility and animosity, and insufficient and inadequate medical care. Such efforts as described in this paper must be interpreted within that frame of reference.

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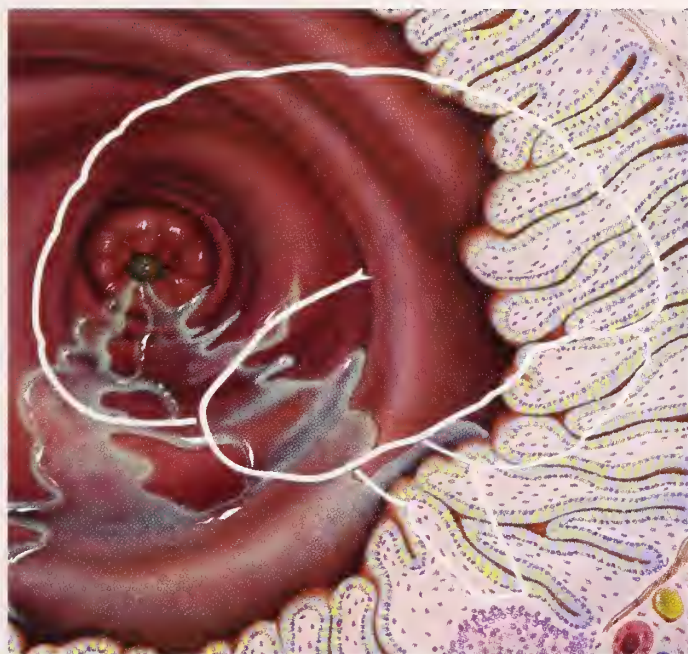
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An important essential relationship exists between the function of the lymphoid system and malignancy. Experimental interference with the immune system renders animals more susceptible to malignant conversion by oncogenic viruses. Patients with immunodeficiency diseases and patients undergoing immunosuppressive therapy for allotransplantation experience incidences of malignancy which are much greater than ordinarily expected. The prognosis of patients with cancer can often be accurately predicted by measuring the vigor of the cellular component of the immune system.

The Immunology of Malignancy

**Norman T. Berlinger, M.D.,
New York***

Over the past 15 years a large body of evidence has accumulated, which demonstrates that the functions of the immune system and both the induction and progression of neoplasia are inextricably linked.

Evidence from Experimentally Induced Immunodeficiencies

Vandeputte was the first to show the relationship between immunodeficiency, in the form of neonatal thymectomy, and DNA virus-induced neoplasia.¹ Neonatally thymectomized rats developed significantly more kidney and bone sarcomas when inoculated with polyoma virus than did nonthymectomized control animals. Defendi showed the same phenomenon to hold for hamsters.² Allison and Taylor inoculated neonatally thymectomized rats with simian virus 40 (SV40) and showed an increased number of tumors after a shorter latent period compared to nonthymectomized controls.³

More recent studies have demonstrated that antilymphocyte serum (ALS) is often even more effective than neonatal thymectomy in enhancing the development of DNA virus-induced tumors. Susceptible CBA mice became exquisitely sensitive to the induction of adenovirus tumors when treated with ALS.⁴ When C3H mice are treated with ALS as neonates, they frequently developed parotid tumors after inoculation with polyoma virus.⁵

Of paramount importance in such virus-induced tumor systems is the finding that antiviral antibody titers in both the immunosuppressed and

control animals were similar.⁶ As a consequence, the demonstration of increased numbers of tumors in immunosuppressed animals cannot be attributed to increased virus replication in these animals due to a lack of an appropriate humoral response to the oncogenic virus. In fact, when the immunodeficient animals were treated with syngeneic immune lymphoid cells, tumor frequency decreased, indicating a direct role of the T-lymphocytes in the prevention of viral oncogenesis. This did not occur when the animals were treated with immune serum.

Evidence from Immunodeficiency Diseases

The evidence for a relationship between immunity and malignancy from the study of human immunodeficiency diseases is striking, but it fails to elucidate the nature of the cause and effect relationship if such exists. Of the approximately 60 patients with Bruton's agammaglobulinemia who have been so far studied, five have developed malignancies.⁷ All these malignancies were leukemias or lymphomas and, significantly, none was derived from epithelial, mesenchymal, or nervous system tissue. One may speculate that, since all observed malignancies were either leukemias or lymphomas, the immunodeficiency is not causally related to the development of the cancer, stemming from a mechanism of deficient

*This study which was supported in part by a fellowship from the National Cancer Institute (1-F22-CA01311-01) was presented as part of the 3rd Franklin Keim Memorial Seminar, held in Newark, October 2 to 4, 1975. Dr. Berlinger is a Fellow, Clinical Immunology Service, Memorial Hospital for Cancer and Allied Diseases, and Research Associate, Sloan-Kettering Institute for Cancer Research, New York.

"immunosurveillance." Rather, it is possible that the development of these types of malignancies could be due to chronic antigenic stimulation leading to an abnormal proliferation of lymphoid tissue due to the significant lack of normal immunoglobulin feedback mechanisms. Alternatively, speaking to the same hypothesis, lymphoid cells of such patients could release oncogenic viruses in response to such chronic antigenic stimulation. It is interesting to note that in another primary immunodeficiency disease, severe combined immunodeficiency, seven cases of malignancy have been reported, all of them leukemias or lymphomas.⁷ However, it may be valid to state that the absence of solid tumors in such patients may be due to the inability to mount an antibody response to an incipient solid tumor, which can become perverted to serving a "blocking" function analogous to the blocking antibody description of the Hellströms. Other evidence in favor of a deficient "immunosurveillance" mechanism in immunodeficiency diseases comes from the reports of two individuals with selective absence of IgA, who individually developed a gastric carcinoma and a bronchogenic carcinoma.⁷ Since these carcinomas occurred at anatomical sites where IgA is normally found in its secretory form, one may argue that the gastric and pulmonary surveillance mechanisms in these patients were severely compromised.

An analysis of malignancies occurring in other immunodeficiency diseases does not clarify whether there is a cause and effect relationship between decreased immune function and the development of malignancy in humans. Ataxia-telangiectasia involves the skin, blood vessels, and central nervous system in addition to abnormalities of both T-cell and B-cell responses. Of the 450 cases of this disease so far reported, 45 individuals have developed cancer, including five epithelial malignancies, two mesenchymal malignancies, and two nervous system tumors.⁷ The Wiskott-Aldrich syndrome is characterized by thrombocytopenia and eczema, and also by T-cell and B-cell abnormalities. A few solid tumors have been discovered in these individuals.

In considering these two diseases, the development of malignancies in these patients may merely reflect fundamental genetic defects which

are the direct causes of the entire syndrome including the immune deficiencies as well as the malignant state. In other words, the immunodeficiency and the malignancy are direct and *independent* consequences of a basic genetic abnormality. Supportive for such a formulation is the analysis of inherited disorders with a high cancer risk but no immunopathology. Fanconi anemia is a disorder resulting in marrow aplasia, skeletal defects, and frequent chromosomal breaks and rearrangements. This disease eventuates in malignancy in about 10 percent of the cases,⁸ with squamous cell carcinomas,⁹ hepatomas,¹⁰ and leukemias being observed.¹¹ To date, no significant immunologic defects have been detected in these patients. Klinefelter's Syndrome (XXY) is associated with testicular feminization, sterility, and an inordinate risk of developing leukemia or bronchogenic carcinoma.¹² Xeroderma pigmentosum, a dermatological disease associated with abnormalities of DNA repair,¹³ is a disorder associated with frequent skin tumors but no demonstrable immunologic defects.

Aging and Immunocompetence

Other evidence, albeit indirect, continues to speak to some sort of causal relationship between decreased immunologic function and the development of cancer. The apparent linkage between declining immune function and aging does not appear to be a mere coincidence, for there is evidence for a genetic basis of immunodeficiency during adult life in certain strains of mice.¹⁴ For the human situation it is known that the chances for developing cancer increase with advancing age. The risk of developing cancer at age 90 are 200 times that of age 15.¹⁵ Interestingly, immune vigor wanes with advancing age. Giannini surveyed the tuberculin skin reactivity of nearly 1,300 adult patients.¹⁶ After age 55, the proportion of negative skin test reactors increased with age, and the high proportion of these negative reactors cannot be explained by a decreased exposure to the tubercle bacillus. In addition, nearly 100 percent of younger individuals should be able to be sensitized to dinitrochlorobenzene (DNCB) so that upon later challenge, a delayed type hypersensitivity reaction should be manifested. Only about 70 percent of older individuals show such a cell-mediated immune capacity.^{17,18}

Allotransplantation and Malignancy

Recipients of organ transplants who undergo the necessary immunosuppressive measures to ensure engraftment develop *de novo* malignancies more often than expected in the similar age range of the normal population.¹⁹ These patients develop both lymphoreticular malignancies and solid tumors.

Immunoprognosis of Malignant Diseases

In addition, it is quite provocative that the prognosis of patients with cancer can often be accurately determined by measures of cell-mediated immunocompetence. Eilber,²⁰ Pinsky,²¹ and Catalona,²² have individually demonstrated that, in untreated solid tumor patients, the ability to display a normal cell-mediated immune response to DNCB directly correlates with whether the patient will suffer a recurrence of the tumor after therapy of curative intent. The *in vitro* response of the lymphocytes of cancer patients to stimulation by allogeneic lymphocytes appears to be an accurate measure of cell-mediated immunocompetence. Berlinger,²³ in studying patients with squamous cell carcinomas of head and neck regions, and Twomey²⁴ in studying Hodgkin's disease, both have demonstrated that defects of cell-mediated immunity occur alarmingly frequently in those patients with the most inexorable and therapeutically resistant tumors, whereas this is not so for those who respond favorably to conventional therapeutic modalities.

Since the degree of immunodeficiency has prognostic significance, once a tumor of the aforementioned types is established two conflicting considerations must be entertained. One possibility is that the tumor arose in an individual who always possessed some sort of immune aberration which could have been detected prospectively had the patient been studied. Conversely, one may think that the tumor arose in an individual despite a normal immune system and, once established, the tumor was able to suppress immunologic activity. If the degree of suppression is related to the biological aggressiveness of the tumor, the apparently poorly

functioning immune system is not responsible for the poor prognosis, but may be the coincidental reflection of other processes.

On the basis of these types of considerations, Kersey, Spector, and Good have re-formulated the "immunosurveillance" concept.²⁵ Normal individuals experience a relatively low risk of malignancy because of both the "metabolic surveillance" systems which operate within cells to limit malignant transformation and because of an "immune surveillance" mechanism which can usually rid the host of malignantly transformed cells possessing neoantigens. Thus, patients with Fanconi anemia, Klinefelter's syndrome, or xeroderma pigmentosum experience somatic cell transformation so frequently that even a normal immunologic surveillance mechanism is insufficient. In addition, the predominance of leukemias and lymphomas among patients with primary immunodeficiency disease suggests that other factors affecting the lymphoid system are operative.

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Immunotherapy in all likelihood will become an important adjunct in the treatment of malignancy. However, to employ this modality rationally, the extent of tumor burden, the immunocompetence of the patient, and the timing of the institution of immunotherapy must be considered. Immunotherapeutic modalities take many forms, but all should aim to augment the cellular immune system specifically.

Rational Immunotherapy

Norman T. Berlinger, M.D.*
New York

Immunotherapy for human cancer is in its nascent stage, and, Hersh¹ asserts, few convincing effective trials of immunotherapy have been performed. Nevertheless, the explosion of modern knowledge of the structure and function of the human immune system, and the experimental immunologic manipulations of animal tumors, has laid the foundation on which to construct rationally the immune assault on cancer.

Rationale of Immunotherapy

The basic premise of immunotherapy is that tumor cells possess neoantigens which are different from those of the host. All animal tumor systems, and many human tumors, which have been appropriately studied, do indeed express such foreign antigens. Thus, immunotherapy attempts to exploit this difference by the active induction or passive administration of immune reactants directed against these antigens.

It must be stated at the outset that immunotherapy has a narrow but exceedingly crucial role in the treatment of cancer. Immunotherapeutic modalities can address effectively only a small number of tumor cells, but experimental considerations give strong evidence that every tumor cell of this small number can be eradicated. This is in direct contradistinction to chemotherapy, which can deal with very large numbers of tumor cells but kills only a constant *proportion* of them. This always leaves a small number of malignant cells which can re-establish themselves as potentially lethal masses. Skipper has shown that one leukemic cell inoculated into a mouse can proliferate to a lethal cancer situation.²

Minimal Tumor Burden

Thus, it is obvious as to precisely where immunologic modalities lie in the therapeutic regimen. For the rational employment of immunotherapy, the first general consideration is to bring the patient to minimal tumor burden by employing conventional surgical, radiologic, and chemical means. Another sound argument for this initial approach is the fact that many tumors, even when small, can elaborate immunosuppressive substances. Israel has shown that some patients with bronchogenic carcinoma, who are tuberculin-negative prior to surgery, can convert their skin reaction to positive after resection of the tumor.³ Eilber, employing dinitrochlorobenzene (DNCB) skin testing, accumulated similar observations for patients with melanomas and sarcomas.⁴ Interestingly, Steward⁵ and Silk⁶ independently showed that this pre-surgical immunodepression was associated with a serum factor which could suppress *in vitro* immune responses. Surgical resection of the tumor was associated with the disappearance of this factor from the serum of the patients.

Immunocompetence of Patient

Another consideration for the rational employment of immunotherapy is the fact that a patient will benefit from this modality only when he is immunologically competent. It is well known that patients with solid tumors can demonstrate profound depressions of cell-mediated immunity (CMI). Eilber and Morton,

*Dr. Berlinger is a Fellow, Clinical Immunology Service, Memorial Hospital, and Research Associate, Sloan-Kettering Institute for Cancer Research, New York. This study, supported by a fellowship from the National Cancer Institute (1-F22 CA01311-01), was presented at the Keim Memorial Seminar, Newark, October 2-4, 1975.

using the ability to become sensitized to DNCB as a measure of CMI, showed that only 50 of 83 patients (60 percent) with potentially resectable cancer exhibited delayed cutaneous hypersensitivity to this immunogen.⁷ Using the same method, Catalona and Chretien showed that 59 percent of 103 similar patients also showed impaired CMI.⁸ Using the mixed leukocyte culture (MLC) as an *in vitro* measure of CMI, Han and Takita showed diminished CMI in many patients with bronchogenic carcinoma.⁹ Berlinger and Good extended these observations to patients with squamous cell carcinoma of head and neck regions, finding that 47 percent of these patients show significant defects in CMI as measured by MLC reactivity.¹⁰ In fact, by various immune parameters, it is this latter group of patients which shows the most frequent and most profound defects of CMI as compared to all other solid tumors studied.

Therefore, it makes little sense to attempt the immunotherapeutic attack unless the patient is already immunocompetent. If not, immunotherapy may still be instituted if it subsequently can be ascertained that this treatment has restored immunocompetence; this sometimes occurs depending upon the particular modality employed.

Timing

The timing of immunotherapy must be carefully considered. Conventional modalities of cancer therapy often exert temporary but significant immunodepressive effects. Numerous studies have shown that patients subjected to the stress of surgery manifest depressed lymphocyte phytohemagglutinin (PHA) responses 24 hours after surgery with recovery usually beginning by the tenth post-operative day.^{11,12} Park has shown that the most profound depressions occur in patients undergoing cardiac valve replacement or extensive cancer operations.¹³ Stjernswärd, in following 34 women who had received adjunctive radiotherapy to supraclavicular and internal mammary lymph nodes after mastectomy, noted lymphopenia, decreased PHA responses, and decreased numbers of circulating T-cells for as long as one year.¹⁴ Al-Sarraf has shown that impaired lymphocyte reactivity to PHA in solid tumor patients can be worsened by chemo-

therapy.¹⁵ Anesthetic agents, to date, do not appear to exert immunosuppressive effects.¹⁶ Obviously, after conventional modalities of therapy have been completed, the cancer patient who is a candidate for immunotherapy must be monitored to ascertain that any resultant immunosuppressive effects have subsided.

Augmentation of Cell-Mediated Immunity

Another fundamental consideration is that the immunotherapeutic modality employed should be aimed at augmenting the cellular immune system only, since the production of deleterious blocking antibodies, as described by the Hellströms, is well known.¹⁷

Methods of Active Immunotherapy

Active immunotherapy (the direct enhancement of the patient's own immune capacity) often combines specific and non-specific approaches. In the treatment of acute lymphocytic leukemia, Mathé achieves maximal cytoreduction with chemotherapy and radiotherapy. Then the patient receives allogeneic leukemia cells and BCG at weekly intervals. He is achieving remission durations which approach five years.¹⁸ Crowther has employed a similar therapeutic regimen with equally impressive results in adults with acute myelogenous leukemia.¹⁹

Non-specific active immunotherapy is currently the most common modality employed, usually taking the form of BCG administration without the concomitant use of autologous or allogeneic tumor cells. Gutterman has treated patients with malignant melanoma, after surgical removal of all known tumor, with BCG by scarification.²⁰ Compared to those patients treated by surgery alone, the patients receiving immunotherapy had both prolonged disease-free intervals and survivals. Donaldson has treated patients with advanced head and neck cancer with methotrexate and BCG.²¹ He noted a complete and partial response rate of about 80 percent compared to an historical control rate of 35 percent for methotrexate alone. The only other non-specific immunologic stimulant to have been used on a widespread basis is *Corynebacterium parvum*. In treating patients with metastatic solid tumors, Israel noted that the survival duration of patients receiving both *C. parvum* and chemo-

therapy was twice that for patients receiving chemotherapy alone.²²

Transfer Factor as Passive Immunotherapy

Transfer factor is a dialyzable extract of sensitized leukocytes which transfers cellular immunity from a skin test positive donor to a skin test negative recipient. Spitler has found that relatives of patients with malignancy show cellular immunity to that malignancy as deduced by *in vitro* methods. Six patients with minimally metastatic malignant melanoma were treated with transfer factor prepared from such donors with sensitivity to melanoma. Two patients showed a clinical response manifested by regression of the tumors.²³ Horn has treated two patients with hypernephroma with transfer factor from family members demonstrating CMI to hypernephroma cells. When the transfer factor therapy was combined with BCG, a significant antitumor effect was produced.²³ Levin has reported clinical improvement of a patient with osteogenic sarcoma treated with transfer factor from a healthy family member who displayed *in vitro* cellular immune responses to the patient's tumor. This improvement continued for seven months with repeated administration of transfer factor until irreversible deterioration occurred.²⁴ Stemming from the evidence for an association between nasopharyngeal carcinoma and the Epstein-Barr virus, transfer factor prepared from individuals who have recovered from infectious mononucleosis has been used to treat this malignancy. Two patients so treated experienced tumor regressions, one of which was associated with lymphocytic infiltration of the tumor.²⁴ An obvious advantage of transfer factor therapy is that only CMI is augmented, and, thus, the humoral immune system which could produce blocking antibodies is left unaffected.

Bone Marrow Transplantation

Bone marrow transplantation has its own unique position in the therapy of human malignancy.²⁵ Up to now, the limiting factor in treating tumors such as neuroblastoma, lymphosarcoma, Hodgkin's disease, and oat cell carcinoma, which are quite sensitive to chemotherapy or radiotherapy, has been the irreversible damage which the bone marrow would suffer when these modalities were to be employed vigorously with

the aim of "total eradication" of the tumor. The ability to replace bone marrow now enables doses of these modalities to be used which are above the level of irreversible bone marrow damage. In such cases, the patient can be reconstituted with marrow from an appropriately HLA (histocompatibility antigen) and MLC matched donor, or with his own marrow which had been previously aspirated and stored frozen.

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Highlights in American Medicine — Growing Penicillin

It is, of course, well known that penicillin was discovered by accident in 1928 by Alexander Fleming, a British bacteriologist, when he noticed that a strange mold growing on a dish of streptococci was destroying that bacteria. He found that the same mold destroyed bacteria that causes pneumonia, diphtheria, and throat infections. Fleming reported his discovery, only to find the scientific community wasn't interested. It was put aside until World War II and its acute need of something to fight infection in wounds, when the supply of sulfa drugs from Germany was cut off.

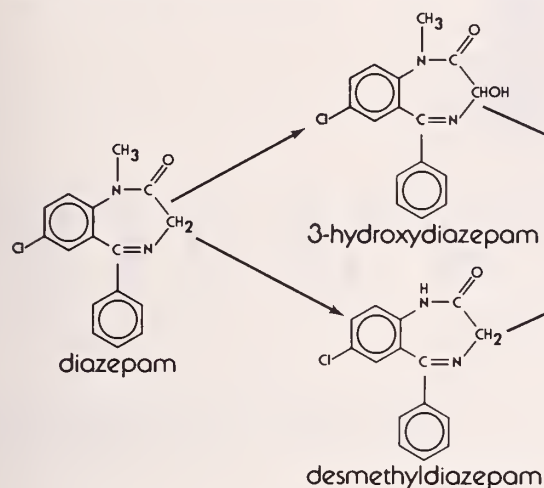
In 1940 an Australian pathologist and a German refugee chemist, working in England, succeeded in extracting pure penicillin from the mold. But the supply of penicillin was limited, and the job of finding either a mold or a broth that could produce penicillin rapidly and in huge quantity

was handed to America.

Scientists in a U.S. Department of Agriculture laboratory in Peoria, Illinois, went to work. One of the first hired for the project was a young girl whose assignment was the purchase of decaying food at local markets. A rotted cantaloupe provided the answer. The mold growing on the melon produced 50 times as much penicillin as the original Fleming strain. The age of the antibiotic had arrived.

In 1945 the Nobel Prize went to Fleming, Howard Florey, the pathologist, and Ernest B. Chain, the chemist. Fleming was knighted by the Queen of England. When Fleming died, flags on the most remote Greek islands flew at half mast, and the flower vendors of Barcelona emptied their baskets before the tablet that had marked his visit to their city.

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to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated:

Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma;

may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients.

Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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The hemodynamics involved in cellular perfusion are multiple and subtle changes may go unrecognized. The development of the Swan-Ganz flow-directed catheter permits easy catheterization of the pulmonary artery at the bedside without x-ray control. This technique now allows the clinician to measure many physiologic variables of both the right and left sides of the heart. The addition of a thermistor at the end of the catheter further permits thermodilutional cardiac outputs to be performed with great frequency. The indications for pulmonary artery cannulation are discussed in this paper. No invasive technique is without potential hazard and the complications of this procedure are discussed.

Physiologic Monitoring of the Critically Ill Patient

Maxwell Borow, M.D., Somerville*

Life is a fine balance between conditions which sustain the living cell and other forces, which, if unchecked, would destroy it. Equilibrium is maintained as long as the cell receives its nutrients, but if the cell is deprived of its energy substrates, failure will occur within a very short time. If this delicate balance is altered to the point at which the metabolic requirements for energy generation exceed the supply of substrates and oxygen, the cell is imperiled. The supply of nutrients to the cell is dependent upon systemic transport and adequate tissue perfusion.

The usual mechanisms causing poor perfusion are diminished effective circulating volume or inadequate cardiac output. When tissue perfusion is inadequate, it not only lessens the quantity of available nutrients such as glucose, amino acids, and fatty acids but it also limits their passage into the cells' pathways.

Energy Pathways

The nutrient molecules enter the cell by means of an energy-requiring transport system derived from two metabolic pathways (Figure 1). The first part of the energy cycle is anaerobic and is the process of glycolysis. In this phase glucose is converted to glucose-6 phosphate which may be stored in the liver and muscle mass as glycogen or may be utilized immediately by conversion into 2 pyruvate molecules. This process yields approximately 6 ATP energy molecules. Normally, with adequate tissue perfusion and the

availability of oxygen, the next portion of the energy pathway is aerobic with the conversion of pyruvate to acetyl coenzyme A, which in turn enters the Krebs cycle and, with oxygen, undergoes four dehydrogenations to release carbon dioxide and energy in specific steps. This process occurs within the mitochondrial matrix of the cell and the liberated energy in the amount of 36 ATP molecules is then used to maintain the ionic pump mechanism which keeps potassium within and sodium out of the cell.

If organ perfusion is inadequate and/or oxygen is not available for this aerobic phase of the energy pathway, the pyruvate molecules cannot enter the Krebs cycle but instead are converted to lactate, releasing only a very small amount of ATP energy molecules.

With inadequate energy fuel for the cell, a sequence of cellular changes occurs as follows:

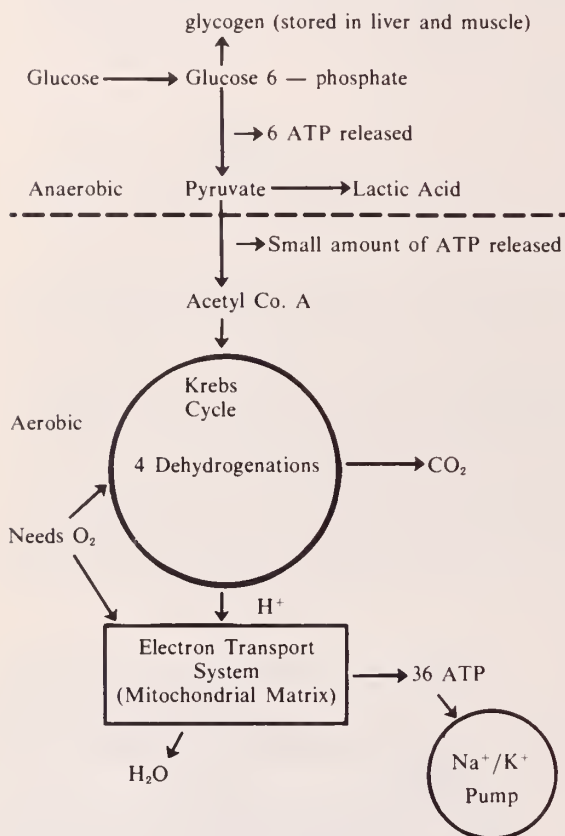
- (1) The cellular membrane potential decreases permitting the sodium ions to enter and the potassium ions to leave the cell.
- (2) All available ATP is mobilized until this source is exhausted. When oxygen is not forthcoming, the energy levels decrease resulting in more sodium and water entering the cell causing edema, mitochondrial and endoplasmic reticulum swelling and further cellular membrane changes.
- (3) The cellular response to insulin, glucagon, catecholamines, and cortico-steroids is altered.

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Figure 1 — Energy Pathways

Nutrient molecules enter cell by means of energy, requiring transport system derived from 2 metabolic pathways:

- (1) Anaerobic — glycolysis
- (2) Aerobic — (a) Hexose monophosphate shunt produces sugar (ribose-5-phosphate needed for synthesis of both RNA & DNA)
(b) Krebs cycle — maintains cell and Na^+/K^+ pump



(4) If this process is not reversed, the metabolic functions of the cell diminish, nuclear function is decreased, the lysosomes within the cell leak and the cell is destroyed.

The severity of the alteration in cellular function depends upon the degree of ischemia and the organ involved. In the liver, gastrointestinal tract, and kidney from which the major blood flow is deviated early in inadequate tissue perfusion, one can expect earlier cellular changes; whereas the brain, heart, and lungs, whose perfusion is maintained at the expense of the above organs, will develop cellular changes later. Initially, these changes are reversible but the viability of the cell is threatened if inadequate perfusion persists.

The hemodynamics of tissue perfusion are complex, therefore, the therapy needed to bring about a homeostatic equilibrium may also be complex and subtle. It is important to recognize all the hemodynamic abnormalities to prevent or to treat rapidly inadequate organ perfusion. The following paragraphs will deal with the currently available techniques to monitor organ perfusion.

Central Venous Pressure

Within the last several years, tremendous strides have been made in the recognition and understanding of the pathophysiologic alterations which occur in the cardiovascular system of the critically-ill patient. The development of the Swan-Ganz flow-directed catheter and the availability of cardiac output measurements represent two of the most significant advances in the understanding, diagnosis, and treatment of patients with cardiovascular and respiratory derangements. The development and use of central venous pressure (CVP) as a monitoring technique was a significant advance of a decade and a half ago and it still remains as the simplest and one of the most important of monitoring devices.¹ Since CVP is the result of the interaction of several factors including venous tone, right ventricular compliance, competency of the right ventricle, venous volume of blood, and intrathoracic pressure, it is strictly an indicator of the competence of the right heart in accepting and expelling blood. If there is a disparity between the pulmonic and systemic circulations, CVP may not reflect the hemodynamics involving the left side of the heart.^{3,17} Such a disparity can be seen in patients with left ventricular failure and particularly in those with an acute myocardial infarction who are on inotropic or vasopressor therapy.

Excessive blood transfusion can occur without significantly affecting the central venous pressure as long as the right heart is able to handle this excess fluid load.² This is understandable physiologically if one recalls Starling's law governing myocardial fiber contraction. As the myocardial fiber length increases, the energy of contraction also increases up to the optimum length of the muscle fiber; with further lengthening, the energy of contraction diminishes. CVP may also fail to clarify the physiology in-

dividuals who may have more than one circulatory derangement, e.g., the patient who develops left ventricular failure secondary to poor coronary perfusion as a result of hypovolemic shock.² In certain hyperdynamic states, such as septic shock, the CVP may be normal or increased even though additional fluids may be necessary. For these reasons, particularly if there is an imbalance between the right and left ventricles, it is important to assess left ventricular function.

Pulmonary Artery Wedge Pressure

In applying Starling's law of the heart in which the strength of myocardial contraction is a function of the end diastolic muscle fiber length, it can be appreciated that the most reliable measurement of cardiovascular function is left ventricular end diastolic, or filling pressure.

Unfortunately, measurements of this parameter are not mechanically feasible. However, other right-sided cardiac pressure measurements have been proven to be simple substitutes. It has been demonstrated and confirmed that, in the absence of mitral stenosis, the pulmonary artery wedge pressure is equal in magnitude to the left ventricular diastolic pressure. With the development of the Swan-Ganz balloon flotation catheter in the late 1960's, a simple, reliable, and relatively safe approach to the catheterization of the pulmonary artery was created.¹⁹ This device consists of a soft flexible plastic catheter with at least two lumens. One lumen is at the end of the catheter and the other is used to inflate a latex balloon positioned near the catheter tip. After the catheter has been introduced into the circulation and threaded into the right atrium the balloon is inflated and the flow of blood carries the catheter through the right atrium and tricuspid valve into the right ventricle and from there into the pulmonary artery and to a branch where wedge pressures can be performed. This can be accomplished with safety and relative ease, with or without x-ray control. When a distal branch of the pulmonary artery is occluded by inflating the balloon, pressure is transmitted backwards from the pulmonary veins to the vessel being measured. In practice the pressure measured in the wedge position clearly reflects the pressure in the pulmonary veins.¹⁷

Pulmonary venous pressure mirrors the left atrial pressure, which in the absence of mitral valvular disease, corresponds to left ventricular diastolic pressure. Through the rest of this paper, the terms "left ventricular filling pressure" and "pulmonary artery capillary pressure" or "wedge pressure" are used interchangeably.

Cardiac Output

Triple lumen catheters are now available by means of which pressures in the right atrium and in the pulmonary circulation can be recorded simultaneously and, in addition, a truly mixed venous blood sample can be obtained from the pulmonary artery. A further refinement is the addition of a thermistor placed near the catheter tip for the measurement of cardiac output by the thermodilution technique (Figure 2).

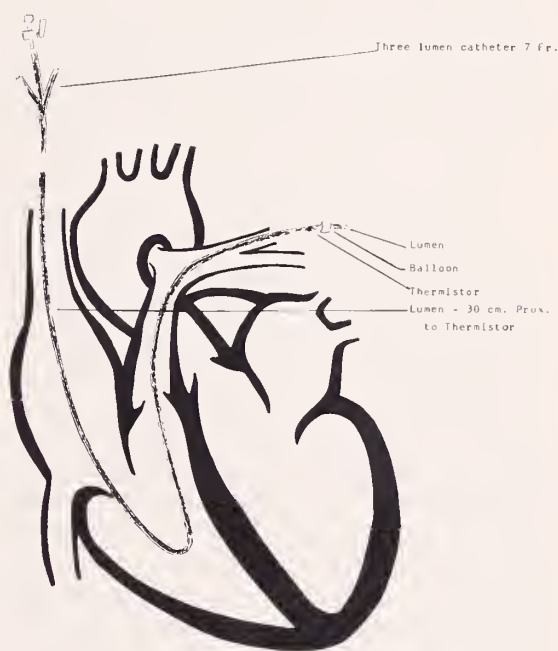


Figure 22

Until recently, cardiac output determinations were mainly an investigational tool. However, with simplification of the techniques involved and the recognition that the hemodynamics in the critically-ill patient may vary, clinicians have begun to use cardiac output measurements in severely ill patients. Cardiac output determinations are based on the Fick principle, as

outlined in 1870 by Adolph Fick, who proposed that flow in a given period of time could be determined by the quantity of an indicator substance entering the circulation, divided by the difference in concentration of that substance before and after its injection. Initially, oxygen was used as the indicator with the formula as follows:¹¹

Cardiac output (L/min) =

$$\frac{\text{O}_2 \text{ consumption (ML/min)}}{\text{arterial O}_2 \text{ content} - \text{venous O}_2 \text{ content}}$$

In clinical practice, using oxygen as an indicator was difficult because of the need to measure oxygen consumption and, in order to determine the oxygen content of mixed venous blood, it was necessary to get a venous sample from the right ventricle or pulmonary artery. In the 1940's, the technique of using indocyanine green as an indicator was developed. With the development of an electronic computer which could be programmed to the densitometer to detect the indocyanine green, this mode of determining cardiac output became even easier and has been the standard tool for cardiac output until recently.¹⁶

In 1965, Fegler proposed thermodilution as an indicator for the Fick principle in cardiac output determinations.⁷ If a cool solution of known quantity and temperature is introduced into the circulation, the difference in temperature measured downstream allows for the calculation of net blood flow as determined by the Fick principle. The advent of the Swan-Ganz balloon flotation catheter with a thermistor placed on its tip has facilitated this technique so that, at the present time, thermodilution cardiac output appears to be the method of choice in clinical practice. Though it does require one invasive technique (passage of the catheter into the pulmonary artery), it also has the advantage of not requiring withdrawal of blood samples, while repeated measurements can be performed very rapidly at the rate of two per minute. Furthermore, physiologic fluids are used as the indicators. The accuracy of cardiac output by the thermodilution technique approximates \pm two percent.^{6,12} Errors can occur if the injection is not performed rapidly or if the catheter is against the wall of the pulmonary artery or in the wedge position. The technique

consists of injecting a solution of known volume and temperature into the circulation through one lumen of the Swan-Ganz catheter at or near the superior vena cava-right atrium junction and as this solution flows past the thermistor 30 cm. distal in the pulmonary artery, the temperature difference is noted. Knowing the volume of fluid injected and the temperature difference, the cardiac output can be calculated. There are several electronic computers available which can be tied into the system and programmed to compute the cardiac output with a digital readout. Most of the Swan-Ganz catheters used for this technique have an additional lumen at their tip so as to permit the monitoring of pulmonary arterial and venous wedge pressures and the collection of samples of mixed venous blood. Thus, with this catheter the clinician is able to measure many physiologic variables: central venous pressure, pulmonary artery wedge pressures, mixed venous oxygen content and cardiac output. In addition, oxygen consumption, pulmonary vascular resistance, total peripheral resistance and left ventricular contractility can be calculated (Figure 3).

Clinical Application

Myocardial Infarction — the balloon flotation catheter mainly has been used in the management of patients with acute myocardial infarction. The principal data obtained from this technique include the filling pressures of the right and left ventricles and the cardiac output. Normal values for right ventricular diastolic pressure are zero to 6 mm Hg and for left ventricular diastolic pressure, 8 to 12 mm Hg. The average cardiac output in healthy adult individuals is about six liters per minute, but there is a wide variation in individual normal measurements because of differences in body size. Though cardiac output and surface area are not strictly proportional over a physiologic range, the relationship is close enough to make the ratio of output to body surface area an acceptable compromise for comparative measurements:

$$\text{Cardiac index} = \frac{\text{cardiac output}}{\text{body surface area}} = 2.5\text{L/min per M}^2.$$

A cardiac index below 2.3L/per M² suggests the onset of heart failure; if less than 2.0L/per M² it

Figure 3 — Formulae derived from Central Vascular Studies

$$(1) \text{ Cardiac output (L/min)} = \frac{\text{O}_2 \text{ consumption (ml/min)}}{\text{Art O}_2 \text{ Content} - \text{Venous O}_2 \text{ Content}}$$

Normal value = 6L/min

$$(2) \text{ Cardiac Index} = \frac{\text{Cardiac output}}{\text{body surface area}} = 2.5 \text{ L/min/M}^2$$

↑ Septic Shock

↓ Hypovolemia, pulmonary embolus, cardiogenic shock

$$(3) \text{ Stroke Index} = \frac{\text{C.I.}}{\text{P}} \quad \begin{array}{l} \uparrow \text{septic shock, bradycardia, hypervolemia} \\ \downarrow \text{Cardiogenic shock, hypovolemia} \end{array}$$

Fixed S.I. — valvular disease

$$(4) \text{ Left ventricular stroke work} = \frac{(\text{C.I.} \times \text{BP}) 13.6}{\text{Pulse rate}}$$

(gm/M/M²)

$$(5) \text{ Total Peripheral Resistance} = \frac{(\text{BP} - \text{CVP}) 79.9}{\text{C.I.}}$$

(dynes — sec/cm⁵/M²)

↑ Cardiogenic shock, hypertension, hypovolemia

↓ Septic shock, vasodilation

$$(6) \text{ A-V diff.} = \text{Art O}_2 - \text{venous O}_2$$

(vol %)

↑ inLo cardiac output syndromes reflect O₂ extract.

↓ inHi cardiac output syndromes reflect O₂ extract.

$$(7) \text{ O}_2 \text{ Consumption} = \text{C.I.} \times \text{A-V Diff.} \times 10$$

signifies shock. A ventricular filling pressure less than 10 mm Hg indicates hypovolemia for which the patient should receive fluids. A filling pressure over 18 mm Hg heralds pulmonary congestion.

A cardiac index over 3L/per M² is considered elevated and can be seen in hypermetabolic states such as fever, hyperthyroidism, anemia, and septic shock and occasionally in acute myocardial infarction. In addition, there is usually a moderate increase in the left ventricular filling pressure. With the growing mass of data obtained from these measurements, it is now recognized that several different hemodynamic states may exist in patients with myocardial infarction and each may require a different and specific therapy.²⁰

Not all hypotensive patients with myocardial infarction will have a diminished cardiac output; approximately a third of such patients will have a normal or elevated cardiac output. If the cardiac output and pulmonary artery wedge pressures (PAWP) are normal, irrespective of the clinical picture, the patient does not have any cardiovascular pathology and, therefore, does not require therapy to improve cardiac function. Attention must be directed toward finding some other variable which is producing the clinical picture.

One of the most important advances in the pharmacologic therapy of acute myocardial infarction, within the last few years, has been the administration of peripheral vasodilating drugs which rapidly may correct heart failure.³ Im-

Figure 4 — Indications for Central Vascular Studies

Pulmonary Artery Wedge Pressure

- (1) Monitor fluid replacement to prevent pulmonary edema
- (2) Monitor to "optimize" the filling pressure of the left ventricle
- (3) Monitor responsiveness of left ventricle to cardiotonic agents
- (4) Differentiate between massive pulmonary embolus and myocardial infarction

Mixed venous oxygen sample (pulmonary artery)

- (1) To evaluate degree of A-V shunting
- (2) To evaluate adequacy of cardiac output — via extraction of oxygen

Cardiac Output

- (1) To determine etiology of hypotension and shock
- (2) Construct myocardial function curves
- (3) Guide in administration of fluids and cardiotonic drugs
- (4) Monitor "Peep"
- (5) Evaluate poor risk patients for elective surgery.

proved cardiac function from the administration of these drugs has been so striking that digitalis is no longer the drug of choice for therapy of heart failure following a myocardial infarction in many centers. Vasodilators act by reducing the arteriolar resistance, which results in an increase in cardiac output and a decrease in pulmonary capillary wedge pressure. The use of these agents is limited by their tendency to aggravate hypotension due to profound peripheral vasodilation. For this reason vasodilator therapy must be accompanied by careful hemodynamic monitoring of central vascular pressures. Vasodilators currently being used include nitroprusside, 15 mg IV with increments of 5 to 10 mg per minute, and phen-tolamine, 5 mg IV with increments of 0.1 mg per minute.

Pulmonary Edema — Pulmonary congestion is not always indicative of a diminished cardiac output in patients with myocardial infarction. A significant number of these individuals will have normal cardiac output with an elevated PAWP. In such circumstances, therapy should be directed to reducing the filling pressure and not toward improving the cardiac output. Reducing the plasma volume with a non-volume expanding diuretic (ethacrynic acid or furosimide) is the treatment of choice. A PAWP of 18-20 mm of

Hg heralds impending pulmonary congestion; 21 to 25 mm Hg indicates mild to moderate congestion and over 30 mm Hg coincides with pulmonary edema.

Shock — Recent work has extended the usefulness of the balloon catheter technique in the management of patients with such diseases as "shock lung" and other pulmonary problems, renal diseases, and disturbances in fluid volume. The hemodynamics in hypovolemic shock include decreased cardiac output and cardiac index with increased peripheral resistance, decreased stroke volume, mean arterial pressure and CVP when there has been 15 percent or more acute blood loss.^{5,17} However, studies done on patients in septic shock or with large areas of inflammatory tissue show variable hemodynamic data. Most investigators have found the cardiac output in septic shock to be normal or elevated.^{23,26} In some instances, the cardiac output was found to be decreased but such patients were found to be hypovolemic; and with the administration of fluid, the cardiac output improved.²⁴ In a recent study the clinical diagnosis as to the etiology of shock was in error in 40 percent of cases and a true assessment was made only after balloon catheterization and cardiac output were performed.⁴

Mechanical Ventilation — In the management of mechanical ventilation, positive end expiratory pressure (PEEP) is used to reduce the right to left pulmonary shunting and to improve arterial oxygenation. Studies have shown that mechanical ventilation with PEEP elevates the mean airway pressure causing an increase in the pleural pressure.^{15,25} The extent to which airway pressure is transmitted to the pleural space depends upon the compliance of the lung. If the lung is stiff or non-compliant, as seen in acute respiratory insufficiency, minimal amounts of pressure will be transmitted to the pleural space. On the other hand, if the lungs are more compliant than normal, as in emphysema, greater pressure will be transmitted to the pleural cavity. In addition, any increase in abdominal pressure, by ascites, intestinal distention, or other causes, will also be transmitted to the pleural space. The net result is an increase in the mean pleural pressure which can cause a decrease in cardiac filling and thus a fall in cardiac output. This has

been shown to occur in 50 percent of the patients on PEEP and in a third of these patients, the reduction in cardiac output was of sufficient degree to negate any improved arterial oxygen content.¹⁵ A number of clinical studies have shown that the systemic circulatory response to PEEP is not predictable in respiratory failure. Generally, end expiratory pressures of five cms of H₂O or less are well tolerated while the circulatory effects of levels above that are not predictable. Thus, the monitoring of blood gases alone is not sufficient for patients on PEEP ventilation but one should also measure the central vascular pressure and cardiac output.

Post-Traumatic Lung Syndrome — The “shock lung” syndrome is a non-specific reaction of the lung which accounts for a third of the deaths of those patients who die following surgery or major trauma. Since there are so many factors attributed to this entity, it is likely that there is no single etiology but a combination of factors. The most effective form of treatment is prevention; thus, very careful fluid replacement and avoidance of massive over-infusion in the early resuscitative period is mandatory. As the central venous catheter is not accurate in determining left atrial pressure, pulmonary edema may occur without an elevation in CVP.¹⁶ For this reason a balloon flotation catheter should be used early for the diagnosis of increasing left-sided pressure, for more accurate fluid management, and for the sampling of mixed venous blood.

Complications

Complications from the balloon catheterization technique are minimal. The most common complication is damage to the pulmonary parenchyma.²⁰ Unrecognized persistent wedging of the catheter tip can produce a pulmonary infarction. Such infarctions are small, usually asymptomatic, and recognized only on a chest x-ray. This complication can be avoided by monitoring wedge pressures intermittently for short periods of time. The balloon should then be deflated and the catheter continuously can then record pulmonary artery pressure. Rupture of the pulmonary artery has been reported as a result of a too forceful inflation of the balloon. These complications can be avoided by awareness of the personnel as to their potential occurrence.

Though cardiac arrhythmias are extremely rare several instances have been reported.¹³ This complication is due to displacement of the catheter from the main pulmonary artery into the outflow tract of the right ventricle. These arrhythmias can be avoided by constant monitoring; if the catheter falls into the outflow tract, it should be repositioned into the pulmonary artery.

Embolism from thrombus formation on the balloon has been reported.²² For the most part, this seems to occur in patients in a hypercoagulable state. Anticoagulation should be used in such situations although it is not the usual practice therapeutically to anticoagulate patients with balloon catheters. However, in many centers a small amount of heparin (2,000 units per liter) is instilled in the infusate to prevent clotting and dampening of the catheter tip.

Balloon rupture is not uncommon particularly if the catheter is used more than once. The latex membrane possesses the property of absorbing lipoproteins from the blood stream, thereby losing elasticity and favoring disintegration and rupture.²² The rupture is not a hazardous complication since the balloon contains approximately one mm of air. The only potential hazard would be in the patient who may have a septal defect permitting the air to enter the left side of the heart and thus create a coronary or cerebral air embolus.

Like all invasive techniques, balloon flotation catheterization may lead to infection. Thrombophlebitis and septicemia are usually due to poor skin care at the site of the catheterization or due to inappropriate manipulation of the catheter. These complications have resolved immediately upon withdrawal of the catheter.

Knotting of the catheter was reported early in the experience of this technique but since using a heavier (seven French) catheter, this is less likely to occur.²² This complication has not proved to be serious since the catheter can be withdrawn to the site of insertion and the knot removed by phlebotomy if necessary.

Vegetative endocardial lesions of the right side of the heart have been reported in association with permanent transvenous pacemakers and

catheters for central venous pressure monitoring and hyperalimentation. Two recent reports^{11,14} noted a higher incidence of aseptic right-sided endocarditis in patients monitored with an indwelling pulmonary artery catheter. In one study from a military hospital 16.5 percent of the patients monitored with a pulmonary artery catheter developed aseptic thrombotic vegetation on the right side of the heart.¹¹ In a second and larger study conducted in a university hospital the incidence of thrombotic vegetations was found to be 3.4 percent. The overall incidence of aseptic thrombotic endocarditis at autopsy in patients who have not had indwelling catheters is reported to be from 0.4 percent to 4.5 percent.¹⁴ However, most of these were on the left side of the heart; there is an increased incidence of right-sided vegetation in the patients monitored with the Swan-Ganz catheter.

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*B. Blackwell: The Drug Defaulter. *Clinical Pharmacology and Therapeutics* 13:841 (1972).

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Psychological implications of the 1974 gasoline shortage, as highlighted by outpatient psychiatric session material, is reported. Issues of status, dependence-independence themes and emergence of maladaptive and psychopathological behavior are reported. Adaptive and coping mechanisms are reviewed. A plan for dealing with the populace in the event of a similar crisis is presented.

Some Psychological Implications of the Gasoline Shortage of 1974

**Harvey J. Shwed, M.D. and
Seymour F. Kuvin, M.D., Newark***

New Jersey is among the most densely populated states in the United States. With its relatively poor intra-state public transportation system, owning an automobile in New Jersey is virtually a necessity.

With continuing political instability in the Middle East and the capriciousness and vagaries of the oil producers and refiners, another gasoline shortage such as the one New Jersey citizens experienced in 1974 seems most likely.

As psychiatrists in private practice in northern New Jersey, we were impressed by the gas shortage's universal effect on virtually all of our patients and how it became a dominant theme in therapy sessions regardless of age, sex, social class, or diagnostic classification.

Although deprivation with its psychological impact has been well studied, these periods of human privation have usually occurred during times of major social or economic upheaval such as World War II or the economic depression of the 30's.¹⁻⁷ The potentially negative psychological effect on the general population during these crises was deflected and diluted by the engendered sense of common cause and mission against an enemy or set of circumstances that were easily discerned and clearly defined.

The winter gasoline crisis of 1974 occurred dramatically and, for the general population, unexpectedly. We feel it profoundly affected the collective American psyche for the following reasons:

1. The shortage of gasoline brought into sharp focus our reality and fantasy attachments to the automobile whose existence has altered our lifestyle.

2. It came during a decade of economic expansion, affluence, and material abundance to which the general population had become accustomed.

3. It also occurred during a period of cynicism, pessimism, and lack of confidence in elected and appointed government officials.

4. Reports about the continuing oil crisis appeared to be unreliable, inconsistent, and often contradictory.

As the fuel crisis deepened, we noted that patients included this topic with increasing frequency and often with a sense of urgency during part or all of their psychiatric sessions. Not infrequently, patients presented with frank psychiatric symptoms directly related to the fuel shortage. We have undertaken to outline some psychiatric observations on behavior and concerns of patients during this period.

Underscoring and Reminders of Status Differences

Who we are and where we stand in the "pecking order" was keenly highlighted by the energy shortage.

Example: A suburban housewife who frequently discussed status issues vis-a-vis her role as a woman, wife, and young mother, angrily protested how the energy crisis exacerbated her deeply-felt feelings of second class citizenship. As the crisis continued, she railed against the "unfairness" of the situation that would effectively funnel the precious gas into her husband's car which he used for business. Without the use of her automobile, she would lose her independence and sense of freedom.

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Demonstrations by groups of disabled people requesting special consideration highlighted not only the practical considerations of transportation and mobility, but also underscored their profound feelings of status loss imposed on them because of their handicap.

Many of our physician-colleagues were observed experiencing regressive behavior in the form of temper tantrums as they recounted the indifferent manner in which they had been treated by their local service station attendant who had, in effect, punctured their fantasies of self-importance and high social status.

A second type of status problem related to the psychological importance of the automobile and its owner.

Example: A 31-year-old accountant, who came from a poor family, had worked hard to build up a successful and financially rewarding practice. A few months prior to the gasoline shortage he proudly purchased a large luxury car which he felt was commensurate with his newly-acquired socioeconomic status. With bitterness and a resurgence of feelings of inadequacy, he related how his vehicle required inordinate quantities of gasoline and because of this, with the advent of the gas shortage, dramatically depreciated in resale value. "It's just my luck," he reported, manifesting all the signs and symptoms of frank clinical depression.

Dependence and Independence Themes

Many of our patients related how an inner sense of security depended on whether gasoline could or could not be procured. The frequently conveyed sense of well being with lowered tension and anxiety levels was striking as patients described their feelings after acquiring a full tank of gasoline. Associations and comparisons to physiological and psychological contentment and satiety of the infant after having been fed were compelling.

Example: A 53-year-old, divorced librarian recalled the feelings of comfort, security, and allaying of anxiety when, after a long wait in line, she would finally arrive at the gas pump and watch, with increasing satisfaction, the needle of the gasoline gauge move to the "full" mark.

On the other hand, her lonely existence as a divorced woman with two grown children living independently and geographically distant from her was painfully underscored by the gasoline shortage. She became markedly depressed when a neighbor, unfamiliar with the absence of family members, suggested that perhaps someone in the patient's family could share the gas-seeking chores.

Themes of dependence and independence emerged as another broad subject for patients during the "energy crunch." As we have come to depend on the automobile for many of life's necessities, we would expect that those who have psychological problems in the area of dependence and independence would have reacted sharply to the gasoline crisis.

Example: A 24-year-old school teacher with well-controlled diabetes travels 20 miles each way to attend her twice-weekly therapy sessions. An important and recurring theme in her sessions related to her inordinate dependency needs and her conscious strivings for independence. Because of her youthful appearance, she is often mistaken for an adolescent. Her diabetes and reliance on daily insulin injections had also been explored in relation to the "dependence-independence" theme. During the fuel shortage, the patient began one of her sessions as follows: "It's really scary, there's no gasoline . . . I waited for close to an hour at the only station that was selling gas . . . I was only three cars away from the pump when they said, 'no more gas!'" The remainder of the session dealt with the patient's childhood experiences and related feelings of being restricted by her parents with their omnipresent monitoring of her behavior. She also discussed her feelings of dependency relevant to her diabetes. That night, she had a dream which she recounted during the next session. "I was going on a sea voyage. After I boarded the ship and it left the port, I realized that I had left my insulin at home and there was none on board. I was filled with panic." During that session, the patient made a symbolic connection between the insulin syringe and the gasoline pump nozzle.

A variation on the theme of dependence and independence relates to the nurturing or maternal aspects of human behavior. The paradigm of the nuclear family can be applied to the gasoline service attendant and his customers. The service station operator symbolically can be seen as a maternal figure, trying to "feed her rivalrous children," i.e., the consumers. There are "good" and "bad" mothers who can or cannot cope with sibling spats, and those who want to play favorites.

Example: A middle-aged gas station owner in the heart of a downtown northeastern city remarked how anxious, angry, and guilty he felt during the current "gas crunch." "When I have gas and I place a \$3 limit on it so that everyone gets a little . . . then they get angry at me and tell me how they've been customers of mine for 20 or 25 years . . . I get so hassled that I close down the station . . . well, then I get guilty and nervous . . . because after all, they need the gas . . . so I open up the pumps again until I run out or get hassled again."

Distortions of Reality, Paranoid Ideation, and Emergence of Aggressive Feelings

Frank paranoid behavior and emergence of aggressive behavior was noted among some of

our patients. The thin veneer of human sociability, congeniality, and rational behavior becomes painfully apparent when our perception of what is integral and basic to our physical and psychological survival is threatened. The suspicious, territorially-possessive, argumentative, combative, and often violent behavior of people as they jockeyed for their gas allotment is well remembered by all readers who had to line up for gasoline in 1974.

Example: A 29-year-old college teacher waiting in a gasoline line became increasingly angered as another motorist was apparently attempting to break in ahead of him. Each inched forward, the teacher intent on preventing the interloper from successfully getting in ahead of him. The two drivers began to make threatening gestures, finally emerging from their respective cars and almost coming to physical blows until the driver of the intruding car identified himself as the gas station's mechanic who was trying to go on duty.

Adaptive Behavior and Coping Mechanisms

We have thus far focused on maladaptive behavior or the exacerbation of existing personality patterns and problems. However, human beings have psychological flexibility, resilience, and resourcefulness.⁸⁻¹⁰ Thus, after the initial shock and denial of the problem dissipated, it was replaced by a more realistic assessment and we began to see the emergence of healthy adapting and coping mechanisms. The use of car pools, public transportation, and decrease in leisure time traveling were noted. The long waits in lines were made more tolerable as people brought their work, studies, or meals with them. A new part-time occupation emerged: the "car sitter." For some time, the crisis crisis produced unexpected, albeit temporary, psychological benefits.

Example: A 28-year-old university student, with ambivalent feelings toward her mother, reported with a sense of relief that she can limit the visits to her parents' home without increasing her own guilt feelings since the travel restrictions imposed by the fuel shortage prevented her from using the automobile except for work and major shopping trips.

Comments

Psychological studies in the understanding of morale and development of panic suggest that the handling of the fuel shortage, from a psychological point of view, by government officials, was inept. During the dark, early days of World War II a psychiatric observer commented, "it is a feeling of helplessness accom-

panying fear that characterizes panic, the feeling that you are trapped, that there is nothing you can do about it, these are the conditions that predispose to panic . . ."¹¹

Most people are best able to cope with emergencies when the facts and issues are clearly delineated and when strong leadership presents thoughtful, realistic but firm plans and guidelines for solutions and amelioration of the problem. Reports of gas abundance in one area of the country, while emergency conditions prevailed in another, only fed into the individual's skepticism about the reality of the shortage. Spotty and inconsistent rationing plans established on a municipal, county, or state basis produced confusion, poor morale, and the public's loss of confidence in their leaders.

Summary

The winter gasoline crisis of 1974 provided the psychiatric observer with unexpected, psychologically and therapeutically useful material in individual sessions with patients. The shortage underscored how a poorly prepared populace may psychologically react to a crisis. Coping mechanisms, adaptive behavior, and general morale can be enhanced with candid, timely, and accurate reporting of the situation. A centrally defined plan of action, such as rationing, in this case, would have minimized confusion and psychological trauma.

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Quality Education Pioneered by Flexner Report

The education and training of medical doctors in the United States is widely recognized as equal or superior to physician training anywhere else in the world. However, prior to 1910 this training in America was often poor and haphazard and virtually unregulated. There were some very good schools, but there also were many poor ones — schools that operated on budgets of less than \$10,000 a year, admitted students without even high school preparation, and were formed primarily to make money for the proprietors.

In 1910 came the famed Flexner Report and it revolutionized medical education. The report resulted from the American Medical Association's Council on Medical Education request to the Carnegie Foundation to undertake an objective study of American medical education.

Flexner began with background information from the AMA Council on Medical Education which pointed out deficiencies in many medical schools, and he subsequently prepared a report that became the basis for extensive reform. Upon publication of the report, the AMA's Council on Medical Education instituted a formal process of survey and accreditation, in chronological rotation, of all United States medical schools. By 1928 the 155 schools, many of them mere diploma mills, had been reduced to 76 that met the basic requirements for proper teaching. Through the years the number of schools has gradually built up to today's 115, all carefully structured to meet rigid accreditation requirements. And more are on the boards.

In 1910 only two medical schools required a college degree for entrance, most required no college experience at all, and many failed to require even a high school diploma. Flexner's proposal that two years of college science training be required for entrance soon became universally accepted. Today few enter medical school without an undergraduate degree. He also recommended the study program for a medical course of four years that is now widely followed — two years of basic training in life sciences and two more years of training in actually treating patients — the clinical years. And today advanced training beyond the four-year course is accepted everywhere.

It would be difficult to overestimate the impact of the Flexner report of 1910. By exposing the deplorable truth about commercially dominated medical schools, his report, together with the financial support given by the then newly-founded Rockefeller and Carnegie Foundations to medical colleges, inspired the reformation that produced an entirely new age of quality in American medicine.

Abraham Flexner served as the catalyst to bring to fruition the objective sought since its founding in 1847 by the American Medical Association — improvement of medical school standards, methods, and facilities. He continued his studies of medical education in Europe, and later served as the founding head of the Institute for Advanced Study at Princeton. He died in 1959 at the age of 93.

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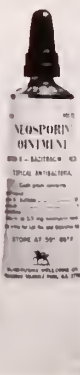
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The case presented is of a twenty-one-year old man who developed a clinically undetected incomplete aortic intimal tear and a non-dissecting aneurysm of the ascending aorta. There was associated cystic medial necrosis, but none of the known predisposing factors was present.

Incomplete Rupture of Aorta with Necropsy Findings

Mercy Kuriyan, M.D., Bound Brook

The two clearest clinical associations with cystic medial necrosis of the aorta are hypertension and genetic weakness of the aortic media.² Marfan's Syndrome¹ is the most familiar example of the latter.

In the following case report we describe a patient who experienced an incomplete rupture and fusiform dilatation of the ascending aorta associated with cystic medial necrosis but who had neither hypertension nor the diagnostic criteria of Marfan's syndrome.² It is our purpose to show that an antemortem diagnosis could not be confidently made from the presenting signs and symptoms.

Case Report

A twenty-one-year-old male had complained of shortness of breath, orthopnea, and weakness over a six-month period. The sudden onset of nausea, vomiting, and the severity of dyspnea precipitated his admission to the hospital. The patient's history disclosed no previous evidence of chest pain, palpitations, cough, hemoptysis, wheezing, abdominal swelling, or edema. The patient was well-mannered and physical examination revealed a well-developed man who was orthopneic and tachypneic. His blood pressure was 125/65 mm Hg. The pulse rate was 120 per minute and the rectal temperature was 38.8°C. An erythematous, macular rash was present in the lumbar region. The chest had a normal configuration and the lungs were free of adventitious sounds and dullness. Cardiovascular examination showed a diffuse bounding apical impulse, present 3 to 4 cm to the left of the midclavicular line. A grade 2/6 systolic mur-

mur was heard at the left sternal border in the 3rd and 4th intercostal space radiating toward the apex. All peripheral pulses were present. The liver was palpable 3 to 4 cm below the right costal margin. There was no peripheral edema. Hyperextensibility of the distal interphalangeal joints was noted. There were no additional abnormal physical findings.

An x-ray film of the chest revealed cardiomegaly mainly involving the left ventricle, interstitial edema, and a slight effusion on the right. The electrocardiogram showed signs of left anterior hemiblock, left atrial enlargement, and left ventricular hypertrophy. The admitting diagnosis was myocarditis, probably of viral etiology.

Laboratory studies on admission were as follows: white blood cell count 11,600 with 74 percent neutrophils and 6 percent bands; blood urea nitrogen (BUN) 49 mg/dl; uric acid 20.4 mg/dl; serum glutamic oxalacetic transaminase (SGOT) 6,090 IU; lactic dehydrogenase (LDH) 4,107 IU; serum glutamic pyruvic transaminase (SGPT) 1590 IU; creatine phosphokinase (CPK) 168 IU; and serum bilirubin 2.6 mg/dl. The red cell count, hemoglobin, and urinalysis were at normal levels. Urine and throat cultures, ANA titers, a serologic test for syphilis (VDRL), and monospot were all negative. Eight blood cultures were negative. The rheumatoid factor slide test was negative. Febrile agglutins and lactic acid level were at normal levels.

*This case report is from the Department of Pathology, Rutgers Medical School, CMDNJ, Piscataway, where Dr. Kuriyan was a Resident in Pathology. She is presently rotating in Clinical Pathology at the Hunterdon Medical Center, Flemington, New Jersey, which is an affiliate of Rutgers.

Clinical Course

Digitalis and diuretics were administered and some improvement was shown. The systolic murmur appeared to increase in intensity. A soft, early diastolic murmur was heard at the right sternal border; S3 and S4 gallop sounds were present. The rash persisted. The patient's pulse varied between 110 to 120 per minute and the blood pressure was 140/60. Except for the digitalis effect, the electrocardiogram was unchanged; chest x-ray continued to show blunting at the right pleural diaphragmatic sulcus. On the 10th hospital day, the patient's condition had stabilized and he was discharged, although tachycardia and gallop rhythm continued.

The patient was readmitted to the hospital 10 days later because of fever, cough productive of yellow sputum, headache, chills, and an increase in weight. The temperature was 39.3C, pulse rate was 110 per minute, and blood pressure was 130/60. The physical examination remained unchanged except for basilar crepitations and neck vein distension. Chest x-ray disclosed an infiltrate in the right lower lung field. A culture of sputum grew diplococci. A diagnosis of right lower lobe pneumonia was made on the basis of the sputum, lung scan, temperature, and x-ray films. On the fifth hospital day, the patient developed signs of congestive cardiac failure with rales, and persistent prominent gallop rhythms. He remained febrile with a spiking temperature. Signs of aortic insufficiency became apparent when a loud diastolic murmur was heard and the blood pressure was 115/50 mm Hg. He developed frank hemoptysis, disorientation, and lethargy. Hyperkalemia, renal insufficiency, and pleural effusions were noted.

Abnormal laboratory studies during the second admission were: white blood-cell count, 9,400 to 14,700 with 81 percent neutrophils and 6 percent bands; BUN, 24 to 85 mg/dl; SGOT, 360 IU; serum bilirubin, 2.8 to 3.1 mg/dl; serum sodium, 110 to 117 mEq/Liter; and serum potassium, 6.8 to 8.3 mEq/Liter. Arterial blood gases on 35 percent Venturi Mask were compatible with a partially compensated metabolic acidosis. Repeated chest films showed increasing infiltrates in the right lower lung and signs of congestive cardiac failure. The electrocardiogram was the same as during the previous hospital

stay except the PR interval had increased and a right bundle-branch block had developed.

Digoxin, diuretics, potassium chloride, tranquilizers and penicillin were given. Heparin and prednisone were administered two days antemortem.

The patient developed idioventricular rhythm, became disoriented and eventually had ventricular fibrillation which was resistant to cardioversion. He died approximately one month after the first admission.

Autopsy Findings

Heart: Weight was 730 grams. There was marked biventricular and atrial hypertrophy and dilatation. The left ventricle measured 1.5 cm and the right ventricle measured 0.6 cm in thickness at their respective bases. The valvular circumference was as follows: mitral valve, 12 cm; tricuspid valve, 14.5 cm; pulmonary valve 7 cm and aortic valve, 14 cm. The valvular leaflets were smooth and free. The endocardial surface was smooth and shiny. The myocardium was red and firm throughout. The right coronary artery ostium was narrowed and the coronary ostia were high. The coronary arteries were patent. No septal defects were seen.

Aorta and Great Vessels: The ascending aorta above the aortic valve was dilated (8 cm in maximum diameter). An irregular scar (2 cm in length) was present about 7 cm above the aortic valve. An irregular transverse ragged tear (2 cm) (Figure 1) was seen in the aortic intima 5 cm above the aortic valve. The arch of the aorta above the scar narrowed (4 cm) and continued as such until the iliac bifurcation. The major arteries and veins were patent.

Other Relevant Gross Findings: Pulmonary emboli were present in the main artery to the right lower lobe and in the smaller pulmonary artery branches in both lungs. Multiple pulmonary infarctions were present. Congestion of the liver (1,850 grams) and spleen (340 grams) was present.

Microscopic Findings

Heart: Hypertrophy of the myocardial fibers was seen. No evidence of ischemia or myo-

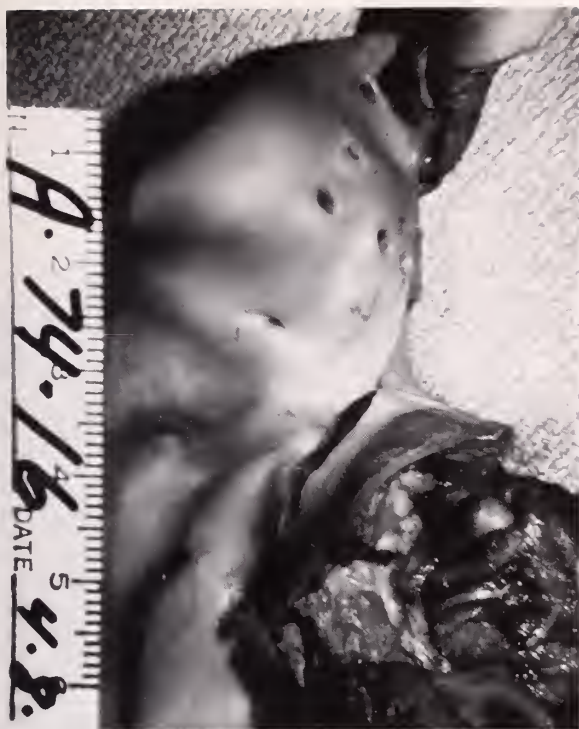


Figure 1 — The intima of the ascending aorta reveals an irregular ragged tear.

carditis was apparent. An organized thrombus was attached to the endocardium of the right atrium.

Aorta: Sections taken from the tear and scar in the ascending aorta, and the ascending, middle and lower aorta, coronary and pulmonary arteries revealed cystic medial necrosis. Special stains with Alcian Blue, PAS, and elastic stains confirmed the histological appearance of cystic medial necrosis (Figure 2).

Discussion

Peery³ described a number of patients with incomplete aortic tears presenting with cough, hemoptysis, fever, and occasional chest pain with associated leukocytosis. They were clinically undetected and most of the cases were associated with hypertension. Our patient had a similar picture but he had no hypertension.

Sudden, unexpected death in young people due to spontaneous rupture of the aorta with associated cystic medial necrosis has been described.⁴ But in all these patients the dissecting aneurysm was most often connected with



Figure 2 — Section of aorta ($\times 25$) stained with hematoxylin and eosin shows cystic medial necrosis and this was confirmed with special stains.

heritable disorders of connective tissue such as Marfan's syndrome or in some instances, Ehlers-Danlos syndrome, or with cardiac malformations and coarctation of the aorta.

In Marfan's syndrome, a relationship between cystic medial necrosis, aortic aneurysm and aortic insufficiency has been described.² These aortic findings were present in our patient but McKusick's criteria² for the diagnosis of Marfan's syndrome were not fulfilled as shown by the absence of family history, and the ocular and skeletal findings associated with Marfan's syndrome.

Aortic insufficiency secondary to spontaneous rupture of the aorta has been reported.³⁻⁵ There also have been reports of aortic insufficiency secondary to aneurysmal changes in the ascending aorta.⁶ Groves and his associates⁶ reported 14 cases in which there was aortic insufficiency, but no intrinsic valvular disease. The pathologic lesions involving the aorta were idiopathic medial necrosis and syphilitic aortitis. Seven of these cases had medial necrosis without evidence of Marfan's syndrome or syphilis. But in all the cases the aneurysm was recognized and surgical

therapy was instituted. This was not so with our case. A similarity to the cases reported by Groves and his colleagues and our case is the absence of intrinsic microscopic aortic valvular disease. The aortic valve was not involved by cystic medial necrosis and the intimal tear did not extend up to or involve the aortic valve. There was rolling of the aortic cusps.

An interesting observation in the present case is the fusiform aortic aneurysm associated with an intimal tear but with no dissection. Hirst and his co-workers⁷ in a review of 505 cases of dissecting aneurysm of the aorta have commented on the common factors important in medial degeneration associated with dissecting aneurysm. Heredity, Marfan's syndrome, hypertension, congenital cardiovascular disease, pregnancy, arteriosclerosis, syphilis, endocrine disorders, infections, and intoxications are considered common predisposing factors to aortic dissection with associated medial degeneration. None of these factors was evident in the present case.

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The Drug Enforcement Administration (DEA) wishes to remind physicians of their duty to report all thefts of controlled substances to the nearest DEA Office. Title 21 of the Code of Federal Regulations, Section 1301.74 requires the registrant to notify the Drug Enforcement Administration of any theft of controlled substances immediately upon discovery. DEA's form 106 should be used for reporting a theft or loss. This form not only serves to notify the DEA but a copy retained by the physician is his official record to account for the disposition of

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Copies of the DEA-106 may be obtained from the Drug Enforcement Administration office in Philadelphia (600 Arch Street, Room 10224, Philadelphia, Pennsylvania 19106, telephone 215-597-9540).

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New Jersey has the highest overall cancer mortality rate in the United States and ranks at or near the top in lung, breast, bladder, intestinal, and rectal cancers. The background of these appalling statistics is discussed. A cancer control program, consisting of a cancer registry, epidemiologic investigation, identification of high-risk areas, early detection techniques, follow-up and treatment, laboratory support, and health education, is proposed. Finally, the roles of various local, state, and federal agencies in this proposed program are outlined.

Cancer in New Jersey: The Problem and Solution (?)*

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New Jersey — the nation's most densely populated state and one of its most highly industrialized — has taken on a new distinction in recent years: the nation's most cancer-prone state.

New Jersey has the highest overall mortality rate for cancer in the United States. New Jersey's cancer rates for males, females, whites and non-whites alike, are in excess of the national rates. For certain specific cancers, the mortality rates in New Jersey are strikingly high, particularly for cancer of the bladder. This malignancy has been shown to be related to certain chemicals, such as beta-naphthylamine, which are used in the manufacture of dyes and pesticides.

At the same time, New Jersey has one of the greatest concentrations of chemical plants in the world. One chemical, vinyl chloride (a known cause of angiosarcoma of the liver) is manufactured in 58 plants in the United States, five of which are in New Jersey.

It is a plausible hypothesis — although, as yet, an unproved one — that part of the very high cancer mortality in New Jersey may be related to environmental factors and, specifically, the occupational environment. In those instances where a cause and effect relationship can be empirically demonstrated between occupational environments and cancer, preventive measures can be instituted that would have a significant effect on the health of the public. Some cancers may be prevented altogether, while alarming death rates can be reduced. When a problem is of this magnitude, a scientifically grounded, people-oriented control program is imperative. This

must use all the expertise of involved and interested federal, state, and local agencies with the New Jersey Department of Health as the lead agency. A discussion of such a cancer control program follows.

Background of Cancer Problem

New Jersey has one of the highest rates of cancer mortality of any state in the nation. In the 20-year period, 1950-1969, Mason and McKay¹ showed that New Jersey led the nation in cancer mortality for white males, with a death rate of 205.01 per 100,000 population, compared to a national rate of 174.04. For white females, the New Jersey mortality rate of 147.92 was exceeded by only one other state, and compares to a national rate of 130.00. For non-white cancer mortality, New Jersey ranks fifth among the states (excluding the District of Columbia) for both males and females, with rates of 230.33 and 163.41 respectively, compared to national mortality rates of 184.28 and 139.18. Mason, *et al.*² showed that almost every county in New Jersey has overall cancer mortality in the top decile for both white males and females.

Most Common Cancers

The relative ratio of New Jersey cancer rates by county as compared to the national rate, by sex and race, is exhibited in Table 1. As can be seen, most cancer death rates in New Jersey are greater than the national average. If the figure is greater than 1, it shows that the New Jersey rate exceeds the national average.

*This study is from the New Jersey State Department of Health.

Table 1

Cancer Mortality Relative Ratio — New Jersey and its Counties to United States Mortality rate, for all Malignant Neoplasms 1950-1969*

	White Males	Nonwhite Males	White Females	Nonwhite Females
New Jersey	1.18	1.25	1.14	1.17
Atlantic County	1.12	1.19	1.12	1.08
Bergen County	1.16	1.53	1.14	1.38
Burlington County	1.08	1.17	1.08	1.01
Camden County	1.18	1.24	1.14	1.27
Cape May County	1.12	1.00	1.10	1.27
Cumberland County	1.04	0.85	1.08	1.04
Essex County	1.24	1.19	1.19	1.11
Gloucester County	1.10	0.99	1.09	1.05
Hudson County	1.33	1.57	1.18	1.42
Hunterdon	1.01	1.61	1.10	2.18
Mercer County	1.18	1.10	1.12	1.08
Middlesex County	1.27	1.51	1.15	1.50
Monmouth County	1.14	1.22	1.13	0.97
Morris County	1.03	1.35	1.04	1.22
Ocean County	1.07	1.44	1.05	1.66
Passaic County	1.20	1.47	1.14	1.31
Salem County	1.07	1.26	1.13	1.16
Somerset County	1.05	1.23	1.04	1.64
Sussex County	1.04	4.96	1.08	3.34
Union County	1.17	1.37	1.17	1.19
Warren County	1.09	1.49	1.14	1.35

*A relative ratio of 1.00 is the U.S. mortality rate. The amount above or below 1.00 is the % above or below the national mortality rate. For e.g. in Atlantic County white males have a 12% greater mortality rate for cancer than the U.S. rate.

(1) *Bladder and Lower Urinary Tract* — This is perhaps the most striking example of a high specific cancer mortality rate in New Jersey. Mason and McKay¹ showed an adjusted white male rate of 9.68, giving New Jersey the highest mortality rate in the nation which is far in excess of the national rate of 6.78. While the rate for white females is high in New Jersey, it is not nearly as striking as the male rate; New Jersey ranks twelfth among the states (5.94 compared to a national rate of 5.05). Such sex-related information suggests the possibility of an occupational relationship among males. Among non-whites, New Jersey shows a bladder cancer death rate which is fifth and sixth for males and females respectively among the states.

County data are even more striking. Mason, *et al.* noted that 18 of 21 counties in New Jersey have white male bladder cancer mortality rates in the highest decile of all United States counties. *The rate for Salem County (16.1) tops all United States counties with a population of over 10,000, and far exceeds the national rate of 6.8. Twenty-five percent of the male labor force of*

Salem County is employed in the chemical industry. While a single large chemical plant in Salem County is suspected as the major source of this high rate, there is obviously a high risk of bladder cancer in many parts of New Jersey which deserves investigation.

(2) *Gastrointestinal Tract and Associated Organs* — The cancer mortality for almost all of the gastrointestinal tract and associated organs is exceedingly high in New Jersey. For cancer of the esophagus, New Jersey ranks fourth and fifth among the states for white males and female rates respectively; for stomach cancer, New Jersey is third and fourth among the states for white males and females; for large intestine, except rectum, New Jersey is second and first for white males and females. The rates for non-whites are not as striking, but are still high, particularly for cancer of the rectum, where the non-white female rate for New Jersey is highest in the country.

New Jersey also shows particularly high death rates among some groups for cancers of the liver, biliary tract, and pancreas. The State is fourth in the nation in white male liver and biliary passage cancer mortality; fourth in white male pancreas cancer mortality; and third in white female cancer mortality.

(3) *Respiratory Tract* — In both the upper and lower respiratory tract, New Jersey has high cancer mortality. In cancers of the tongue, mouth, and oral pharynx New Jersey ranks sixth for both white and non-white males. Similarly, high rates are seen for laryngeal cancer in males, where New Jersey ranks fifth and third for white and non-white males respectively. For nasopharynx, New Jersey is seventh for white males and fourth in rank for white females.

Mortality in New Jersey for cancer of the trachea, bronchus and lung, is high "across the board." New Jersey ranks third for white males, fifth for non-white males, fourth for white females and sixth for non-white females. In county profiles, while *almost all New Jersey counties have high white male mortality rates, it is particularly striking in the more industrial northern portion of New Jersey, in counties such as Passaic, Bergen, Essex and Hudson.*

(4) *Breast* — New Jersey has particularly high rates for breast cancer in both males and females. In all race-sex categories, New Jersey ranks third among the states for breast cancer mortality, except for non-white females, where New Jersey is fourth. *The high rate of breast cancer in females is especially marked in counties near the cities of New York and Philadelphia.*

(5) *Other Cancer* — Relatively high mortality is present in New Jersey for uterine cancer, excluding the cervix uteri, where New Jersey ranks third among white females; for the ovary, fallopian tube, and broad ligament cancer, our State is first for white females and fifth for non-white females.

New Jersey also has high cancer mortality for some categories of endocrine cancers. In thyroid cancers among whites, the State is sixth and third for males and females respectively. For other endocrine glands, the State is fourth for white females. New Jersey also has a high relative mortality for neoplasms of bone in non-whites, ranking third and second for males and females respectively.

Cancer Control

From the long range point of view, *the most effective method of cancer control is prevention.* This is best accomplished by identifying the causes of cancer and curtailing their presence in the environment. In today's state of knowledge, several factors have been thought to be causative of cancer, some of which may be interrelated. These include genetic factors, viruses, and environmental factors. It is now believed that environmental factors play a much larger role in causing cancer than was previously thought.

Preventive aspects of cancer control can be divided into two areas, namely, collecting evidence of what causes cancer and controlling known or suspected cancer causes.

The collection of evidence, supported by scientific findings, necessarily will require a multifaceted approach. On the one hand, compounds with known cancer-causing effects must be located in our personal environments (high-risk

areas must be identified). On the other hand, rates of cancer must be defined. We must know in whom, where, and when cancers of various sites of the body occur (development of a cancer registry). From the basic data, it is possible to scientifically "zero-in" on why cancer rates are high in certain groups and not in others. The working hypotheses can be tested (epidemiologic investigation). Armed with this new knowledge of the causes of cancer, programs of prevention, control, and protection can be designed.

1. *Cancer Registry* — One of the highest priority needs in New Jersey at the moment is a simple cancer registry. This is basic to all the information-gathering systems that will be needed. There is no method now in use to determine the occurrence of cancer in New Jersey. The only source of any knowledge of cancer in New Jersey is mortality data, which are insufficient for the development of adequate information. A registry of the occurrence of cancer in specific populations is needed.

The State Health Department is presently involved in the study of bladder cancer through a grant from the National Cancer Institute. Cases for the study are based on the only registry we now have available — the death certificate registry. Since the casual exposure may have occurred two decades prior to the diagnosis of the cancer, it is obvious that interviewing live patients available through an incidence cancer registry would be much more valuable and productive than the minimal data available on a death certificate.

The data generated by a cancer registry will be most valuable in at least two instances. First, major variations in rates of cancer may be pinpointed. This information will generate hypotheses that can be tested. Secondly, an increased rate of disease in a particular location (such as near an industry, in a particular work setting, or in the delivery pattern of a water supply), should trigger a search for carcinogens in the environment by the Department of Environmental Protection. If particular industries display a pattern of cancer higher than that in populations nearby, a whole armamentarium of occupational health expertise should be set in motion.

The Public Health Council has the power to make cancer a reportable disease and is prepared to do so. But simply to make cancer a reportable disease without the resources effectively to use the data that would be generated by this reporting system would be of little value. What obviously is necessary is the establishment of a system of data utilization.

It is anticipated that reporting of cancer from diagnostic laboratories will be a wholly adequate method for New Jersey since almost every cancer is diagnosed, at some point, in a laboratory. In the climate of laboratory reporting that has already been generated in New Jersey, it is estimated that 95 percent of the cancers could reach the registry by this route alone. The addition of other methods of reporting would get the last five percent, but would so greatly add to the cost of registry that it would not be "cost-effective."

The data from the registry would be available to State and other qualified investigators. Methodology will have to be established to insure confidentiality for individuals, and at the same time provide necessary data for proper investigation.

The cancer registry is necessary to provide the correlation between the occurrence of cancer cases and possible environmental factors. It is also necessary for proper evaluation of cancer treatment and prevention measures that are currently in progress, or will be initiated in the future. The question to be answered is, has the incidence of a particular cancer decreased with the institution of early detection, adequate treatment, and follow-up programs for that particular cancer?

2. Epidemiologic Investigations — The New Jersey State Department of Health is in a position to lead other interested state and federal agencies in investigating possible environmental relationships to high cancer mortality in our state, and to institute appropriate preventive measures and controls. This Department has demonstrated over the years an expertise in epidemiology — the "detective work" of public health — that has become nationally known and respected.

The current example of this ability is the identification by the New Jersey Department of Health of the "Swine" influenza outbreak at Fort Dix; but, other examples in the infectious disease field — in hepatitis and in virus disease spread by mosquitoes — are abundant. In the non-infectious disease area, investigations into relationships of phenothiazines to encephalopathies and possible adverse effects on human health and pesticides have been conducted. Since the expertise required for cancer epidemiology is essentially the same as that which we have already demonstrated in studying infectious and non-infectious diseases, this Department is confident that it can expand into this new area if adequate resources are provided.

The State Department of Health has custody of, or direct access to, vital records and hospital and laboratory reports that are critical to good epidemiologic research. In addition, we have developed a close relationship with hospitals allowing review of necessary records and reporting that has allowed epidemiologic investigations throughout the State. The Department also has regulatory authority of hospitals and laboratories to assure access to data.

Thus, we are uniquely qualified, competent and able to investigate the problem of cancer in New Jersey. The studies embarked upon will allow us to pinpoint the at-risk population and environment, and to institute indicated controls.

3. Identification of High Risk Areas — Fourteen chemical agents already have been recognized as probable or proved human carcinogens by HEW's National Institute for Occupational Safety and Health (NIOSH). The chemicals and their uses are tabulated in Table 2.

We do not know what quantities of these known carcinogens are manufactured, used, or imported into the state. We do not know what plants use them, manufacture them, or produce them as by-products of some process. We know nothing of the identity, or numbers of workers who come in contact with them, nor of the levels to which they are exposed. We do not have the necessary knowledge of the industrial screening and medical services available to the workers exposed to these substances, or the protections

Table 2
Known (or Probable) Carcinogens and Their Uses

<i>Agent</i>	<i>Uses</i>
4-Nitrobiphenyl	Analytical standard
Alpha Naphthylamine	Manufacture of herbicides, dyestuffs, food colors and color film, paint, plastics, rubber and petroleum products.
4,4-Methylene bis (2-chloroaniline)	Curing agent for epoxy and other polyurethane resins.
Methyl chloromethyl ether	Manufacture of ion exchange resins, textiles and drugs.
3,3-Dichlorobenzidine	Manufacture of printing inks, dyes, plastics and crayons.
Bis-chloromethyl ether	Manufacture of ion exchange resins.
Beta Naphthylamine	Manufacture of dyes and pesticides, in photography, and as a chemical reagent.
Benidine	Production of dyes, rubber and plastics, printing ink, fire proofing and in medical laboratories.
4-Aminodiphenyl	As an antioxidant in rubber manufacture and as an intermediate chemical in dye production.
Ethyleneimine	Paper and textile industries in herbicides, resins, drugs, and jet fuel.
Beta Propiolactone	Plastic manufacture.
2-Acetylaminofluorene	Potentially as a herbicide.
4-Dimethylaminoazobenzene	As a dye.
N-Nitrosodimethylamine	As an industrial solvent and in synthesis of rocket fuel.

offered them. We have little idea whether humans acquire cancer from exposure to these substances by repeated occupational contact, or by their release through sewage, air, or other means, even including transport by worker's clothing into their households.

These known significant carcinogens must be traced through New Jersey. We must know how much is imported and how much is produced, who is exposed and what are the consequences of such exposures.

Specific knowledge that carcinogens are utilized in a particular industry will suggest searching the cancer registry for excess cases working in that industry. Failure to identify excess cases will justify re-directing attention to the next highest priority carcinogen. However, documentation of increased risk will mandate further analysis such as length of exposure, adequacy of customary protective devices, interactions with other cancer risks such as smoking, and so on. Suspicious findings from the registry in the en-

viron of an industry using a carcinogen will mandate a search for environmental contamination.

As suspicious agents are suggested, industries utilizing the agent must be tabulated by the Department of Labor and Industry. Carcinogen-use cataloging by the Department of Labor and Industry will be a new endeavor. The law on which this effort will be based will have to be reviewed and the mechanism for its implementation will have to be developed.

The registry, therefore, will be used to evaluate the extent of the potential problem created by industrial use of carcinogens. Most carcinogens will be contained adequately, but when rates generated by the registry suggest, and epidemiological studies confirm, that the carcinogen is actually responsible for cases in a specific locale, controls will have to be instituted to limit the exposure. The laws necessary for such control activities will have to be reviewed, and supplemented where necessary.

Thus, by homing-in on agents demonstrated to be actually carcinogenic, in regions where the registry has identified high cancer rates rather than sampling hither and yon, from the long list of potential carcinogens, we most effectively will expend our resources and protect the public's health.

Based upon the epidemiological investigations of the State Department of Health alluded to above, certain environmental and biological specimens will be obtained from "high-risk" areas and "at-risk" persons by the Department of Environmental Protection and the State Department of Health respectively. The laboratory testing of these specimens will indicate what particular chemicals are polluting the environment, particularly in the work place, and indicate that engineering techniques must be changed to control and prevent the release of these materials, or that known protective measures must be vigorously employed.

The laboratory testing is an integral part of a meaningful occupational health and safety program to insure the well-being of our work force. Currently, due to federal malaise and historically due to weak state leadership, no statewide program of occupational health and safety exists. Such a program should be re-established in the State Department of Health, initially as part of our Cancer Control Program.

The epidemiological investigations that pinpoint the areas to be studied by laboratory methods will lead to true *primary prevention*, i.e., finding a population with a high frequency of a particular cancer, identifying the determinants of that cancer and instituting the necessary regulations and controls to prevent the people from being exposed to or coming in contact with the causal agent.

4. Early Detection: Screening — Certain cancers in the early stages are amenable to mass or selected screening programs which are now sometimes provided by various agencies at various times without coordination. There should be a coordinated effort led by the New Jersey Department of Health, utilizing the expertise of the medical and osteopathic societies, the American Cancer Society, local health

departments, hospital clinics, neighborhood and family health centers, and industrial medical programs, to provide for early identification of rectal cancer by rectal examination, cervical cancer by Pap smear, and breast cancer through professional and self-examination and appropriate use of thermography, mammography, and xerography.

The Department will utilize and encourage those screening techniques that have been found to be cost-effective and technically sound in identifying potential cancers and continually will evaluate newly proposed methods by limited clinical trials before embarking on a mass screening technique. The Department, in essence, will be involved in the *evaluation of the effectiveness of screening techniques*, and then the encouragement to the local agencies to utilize the effective methods, rather than "jumping-on-the-bandwagon" for any newly described procedure.

Several screening techniques that are accepted or are in the developmental stages will be discussed briefly.

Cytological Screening — For a number of years, the use of cytology (the microscopic examination of body cells) has been advocated and studied as a selective screening procedure to identify early cancer in various sites.

Cervical Cytology — The most widely accepted and one of the most easily accessible sites for this technique has been the uterine-cervical smear (Pap test). Cervical cancer discovered early in its course (*in-situ*) by this technique has an almost 100 percent cure rate. The rate drops when the cancer becomes invasive. All women, over the age of 30 years, should have a Pap test at least annually in order to detect the disease as early as possible. A recent study in Massachusetts,³ however, indicated that the most important age groups to test, are not being reached. Routinely, women in the childbearing ages are given Pap tests prenatally, early in pregnancy, in family planning clinics, or during their annual check-up. The study showed that only 44 percent of the total number of Paps were performed on women over 35 years of age. Women in this age group accounted for 97.5 per-

cent of the deaths due to cervical cancer and, more importantly, the *death rate increased steadily with age while the proportion of women who had Pap tests decreased with age.*

The means for early detection and virtual elimination of cervical cancer through proper treatment is readily available, yet each year, thousands of women nationally, and hundreds in New Jersey, die needlessly of this disease. In fact, a study in British Columbia screened 80 percent of the women over 20 years of age and the mortality for this group fell from 11.4 deaths per 100,000 population in 1958 to 6.9 deaths per 100,000 in 1970. The incidence of clinical cancer of the cervix in the screened group was only 14 percent of the unscreened population.⁴

The State Department of Health has recently submitted an application to the Department of Health, Education, and Welfare's National Cancer Institute to support a state-wide program of cervical cancer screening and follow-up in the high-risk populations. This is one of the few programs of cancer control which the NCI budget presently supports. With the proper word from Congress, which "watch-dogs" NCI's budget, some programs of environmentally related cancer control might also be supported in states such as New Jersey.

Bladder Cytology — Certain industrial processes are associated with a high incidence of bladder cancer. Selective urinary cytological screening of this population is of value to identify bladder tumors in their early stages. Such a selective screening program is indispensable in any work setting where the hazard of occupational exposure to potential bladder carcinogens exists. Urinary cytology is also indicated for patients presenting with any symptoms suggestive of urinary tract cancer.⁵

Lung Cytology — Several researchers have advocated that heavy smokers with a productive cough be screened cytologically.⁵ If the sputum shows abnormal cells, then the fiberoptic bronchoscope would allow visualization of all major areas of the lung and possibly locate an operable cancer.

Colon and Rectal Screening — Over 2,000 New Jerseyans die annually from cancer of this site

yet the American Cancer Society contends that approximately 75 percent of these patients might be saved through early diagnosis and treatment. One method being advocated annually for all patients over 40 years of age and those with a history of cancer, ulcerative colitis, polyps or familial polyposis is a take-home specially prepared slide-packet to test for occult blood in stool specimens. On three successive days — because gastrointestinal bleeding may be intermittent — the individual patient smears thin fecal samples on a paper slide and then mails the slides to the physician or lab. The addition of a specially prepared mixture to the sample by the physician or technician produces a bluish-ring on the slide paper if any blood cells are present. Persons must be on a meat-free, high-residue diet. They must not take medications containing iron or aspirin during the testing period, nor be bleeding from hemorrhoids or menses prior to taking the specimens. This test has been well received by patients. It can be used as a mass screening device by labor groups and community organizations, with cooperative physicians and laboratories. It does not provide conclusive evidence of the presence or absence of pathology, but it raises the index-of-suspicion and helps the physician to decide whether and which diagnostic procedures are indicated.⁶

A recent report on a 25-year follow-up study of 18,000 persons older than 50 years emphasizes the value of periodic proctoscopic exams for colon and rectal cancer. Those individuals who had received the periodic examinations had a cancer rate of only 15 percent of that expected if examinations had not been done regularly.⁷

Experimental Techniques — Active research may lead to techniques for identifying potentially carcinogenic agents much earlier than presently is possible. Animal studies have proved meaningful in this regard. Identifying persons in the population who may be more prone to develop cancer due to inherited traits would be useful.

Mutagenesis — If a chemical is carcinogenic, it might also be mutagenic, i.e., capable of producing a genetic change in a cell. It has been found that when such an agent is "fed" to microbiologic systems (e.g., bacterial cells), genetic changes may occur in the cells. In-

dividual cell duplication can be visualized and changes identified more rapidly than from present methods of research which depend on the interaction of agents with animal tissues. This new method to identify potential carcinogens may permit controls to be applied more rapidly, to protect individuals from contact and exposure to the particular agent. This is an important screening technique to which the State's laboratory could be adapted.

Differing Susceptibility to Cancer — Susceptibility to cancer appears to be inherited, or at least a predisposition to develop cancer under the right conditions seems to be inherited. Some persons have a higher susceptibility to develop cancer than others.⁸

Studies in the past indicated that particular types of cancer tended to occur in families. Newer studies, however, show that relatives of cancer victims even appear to be at increased risk for completely different cancers.⁹

Growing evidence indicates that the metabolite(s) of a chemical rather than the parent chemical may be carcinogenic and that the human body reaction to a specific metabolite depends upon certain enzyme levels in the body. One such enzyme which increases markedly with certain chemical exposures is aryl hydrocarbon hydroxylase (AHH). The levels of this enzyme activity appears to be genetically determined. Susceptibility to lung cancer, for example, is associated with higher levels of AHH activity. If this work can be further substantiated, then future screening programs might include tests for "AHH inducibility." Those persons found to have highly inducible enzyme activity would require closer and more frequent screening and possibly even exclusion from the hazardous environment.¹⁰

Work placement physical examinations can be used in enlightened industries: certain workers can do certain things, and should not be introduced to other activities. Placement by standards of physiologic protection does not exclude people from the work place, but rather ensures the use of their talents for a greater number of productive years.

This potential screening technique might identify susceptible individuals before they become exposed to potential carcinogens; primary prevention thus becomes possible.

These techniques are in the developmental stages, but emphasize the fact that, through scientifically grounded programs, we may be able effectively and efficiently to identify potentially hazardous chemicals and potentially susceptible individuals. Then, we may effect a change in environmental contamination and individual exposure in order to prevent cancer.

5. Follow-up and Treatment — All screening programs must provide a mechanism whereby a positive screenee and his physician are notified and proper action instituted. It is, incumbent upon the State in conjunction with the organizations and individuals mentioned above, to make maximum use of present means for detecting cancer in its early stages and to insure prompt definitive follow-up and treatment.

It is not the role of the State to carry out treatment, but it is the State's role to assure the quality and effectiveness of the therapy in each institution after appropriate referral is made. This assurance is accomplished through the State's responsibility to set standards for the operations and staffing of health facilities. Also, the certificate-of-need process ensures that there is a documented need for the cancer treatment modality in a specific area of the state and that the expertise to operate such a facility indeed does exist.

Furthermore, through the development of the cancer registry, institutions would be encouraged to develop active evaluation committees to study the effectiveness of their diagnostic methods and treatments of specific cancers. Once the registry is established and statistics are available, we will be able to recognize that some cancers in certain hospitals are diagnosed much later in their course than in other areas of the State. This can be seen where the five-year survival rate for a specific cancer is markedly different from one area of the State to another. Hospitals will be stimulated to be more effective in increasing their survival rate because

they will not want to look "bad" compared to other New Jersey hospitals.

The New Jersey Cancer Institute, once fully established, will have an integral role in assuring that up-to-date, effective means of diagnosis and treatment are instituted throughout the State. They will depend on the registry to conduct their own scientific investigations of the effectiveness in diagnosis and treatment in various health centers.

6. *Laboratory Support* — Cancer investigators will be searching for carcinogens in human and environmental samples. Control programs, in part, will be based on eliminating exposure to carcinogens. Laboratory facilities capable of analyzing for carcinogens at levels of parts per billion are a necessary part of this effort. Essential to this laboratory effort are a gas chromatograph and support personnel. The chemistry laboratory of the State Department of Health has had experience in the field of gas chromatography, primarily in a pesticide research project, using equipment loaned by the Federal Government. This experience should be expanded.

As mutagenesis testing becomes an accepted screening technique for identifying potential carcinogens, then the State Department of Health Laboratory should be equipped to augment studies performed at the Federal level for chemicals peculiar to or common in New Jersey.

The State Department of Health Laboratory is responsible to insure the quality of the independent and hospital laboratory services through our Clinical Laboratory Improvement Program. This will pertain to cytological examinations, AHH enzyme activity and other tests.

7. *Health Education* — If there is to be control of existing disease, as well as prevention of occurrence and progression of cancer, then health education must be an integral part of each aspect of the program.

The incidence and mortality of several types of cancer, especially lung cancer, are broadly the result of the use of tobacco, particularly cigarette smoking.

If we are to effectuate a real change in cancer incidence and mortality, then this one factor must be attacked vigorously. Tobacco-related cancer can be prevented best, of course, by avoiding the cigarette habit. Educational programs must be developed and directed to sensitive and susceptible age groups especially the young school-age child. This is very important because the younger the individual is when he begins smoking, the greater the chance of developing lung cancer and other related diseases.

For the established smoker other possibilities exist. First is enticing the individual to participate in "smoke-ending" clinics and programs by interesting him more intimately in his personal health and assuring him that the effects of cigarette smoking are not irreversible except after very long, excessive use.

Second is through the release of information on the tar and nicotine content of cigarettes to give smokers the alternative of smoking cigarettes with lower concentrations of these substances. The tobacco industry appears to have been motivated through this technique to decrease the levels of nicotine and tar, because of the potential competition for sales. Ultimately, State and Federal legislation or regulations with maximum allowable concentrations for tar and nicotine may be enacted and promulgated.

Uppermost in cancer control and in any control program is the prevention and early detection of disease. In order for this to occur, there must be a high index of suspicion in the professional and lay community. The cancer control program must by necessity address the health education activities outlined in Table 3.

8. *Role of State Agencies* — Several state agencies are necessary for the implementation of an effective Cancer Control Program. The tasks of each of these agencies as they relate to the entire program are:

Department of Health —

(1) *Registry* — A cancer incidence registry of diagnosed cases in New Jersey patients.

(2) *The epidemiologic process* — Define in whom, where, and when, cancer rates in New Jersey are high. From these

Table 3
Health Education Action, Activities, and Agency Involvement in Cancer Control

<i>Action</i>	<i>Types of Activities</i>	<i>Types of Agencies Involved</i>
Individual action and behavior change	<p>Early attitudinal and value formation as regards one's health (school curricula)</p> <p>Adult education program relating to: seven danger signals for cancer smoking withdrawal avoidance of undue exposure to sun breast self-examination change of dietary practices</p> <p>Occupational programs relating to: wearing protective clothing and equipment and observing protective measures avoidance of known hazards</p>	Schools, Voluntary Organizations, Labor Unions, Management, Community Groups, Professional Groups, Local Health Depts.
Medical and health professionals education	Training and continuing education to improve expertise in: counselling early detection, treatment, control of cancer preventive techniques for high-risk population educating patients	Academy of Medicine, Medical Schools, Nursing Schools, other Health Training Schools, Voluntary Organizations, New Jersey Cancer Inst.
Community action	<p>Control the physical and biologic environment by developing the climate for environmental pollution control, environmental design and safety engineering, and human factors engineering.</p> <p>Control the social environment through: dissemination of information smoking control codes provision of smoking withdrawal resources</p>	Community and Civic Organizations, Elected Representatives, Local Health Depts., Special Interest Groups (consumer groups)

data, establish through further investigation why the cancer rates are high in certain groups and not in others. From this knowledge, programs of prevention, controls and protection can be designed.

(3) *Prevention* — (a) primary — curtail the known carcinogens in relation to populations at risk: (b) secondary — develop new methods, or apply known methods for early detection; and (c) develop and apply workable health education methods to change human behavior to reduce exposure to carcinogens.

(4) *Human Surveillance* — Extend the present health protection of workers and others at risk through surveillance, screening, laboratory back-up and follow-up.

(5) *Referrals to treatment and rehabilitation* — Assist in the development of the appropriate network and ensure referral of patients detected to have cancer to it.

(6) *Program and facility standards* — Through the planning and regulatory process, provide New Jersey with selected high quality cancer treatment sites.

(7) *Food and products safety enforcement* — Continue cooperation with FDA to ensure elimination of carcinogens from food and drug products stored and distributed in New Jersey.

(8) *Health education* — Community based programs, and assistance to Department of Education in teacher training and curriculum development.

Department of Labor and Industry —

(1) *Industrial mapping* — Relate potentially hazardous industrial processes and emissions to geographic areas.

(2) *Historical data* — Define relevant industries active in New Jersey during the last five decades.

(3) *Process surveys* — Locate and inventory suspected carcinogenic substances in the occupational environment. (carcinogen-use cataloging)

Department of Environmental Protection —

(1) *Carcinogenicity testing* — Provide aggregate samples of air, water, and so on to the appropriate research laboratory to be tested for their carcinogenic and mutagenic properties.

(2) *Monitor* — Determine the presence and concentrations of carcinogenic substances in the environments, particularly those to which Department of Health studies point as suspect.

(3) *Inventory* — Determine the use, production, transport and waste products known or suspect of being carcinogenic.

(4) *Emission Standards* — Establish standards to limit the emission of carcinogenic substances into the air and water, or through improper disposal of wastes.

(5) *Cluster monitoring* — Monitor extensively and comprehensively at sites where Department of Health studies show cancer cases to be clustered.

(6) *Permit review* — Review of existing and new permit applications to ensure that carcinogenic substances are not emitted to the environment.

Department of Higher Education —

(1) *Training* of industrial hygiene, occupational health and safety specialists, and continuing education for those currently employed.

(2) *Training* of medical and allied professional manpower for cancer control, treatment and rehabilitation, and continuing education.

(3) *Industrial Research and Development* performs a feasibility study on the academic basing in New Jersey of an industrial R & D Institute to be involved in training, and also in the testing of processes prior to their introduction into the work environment to determine their safety to humans, or alterations which will make them safe. Also test current processes suspected of hazard, for alteration.

Department of Agriculture —

(1) *Investigation of food production* — to determine presence or absence of use of carcinogens, e.g., in animal and poultry feeding.

(2) *Enforcement* — enforce the elimination of carcinogens from food production.

Department of Education —

(1) *Develop curricula* for a total health education program to teach children to develop positive attitudes toward health, self-responsibility, and appropriate decision-making skills relative to cancer prevention, detection and periodic exams.

(2) *Mandate teaching* of the developed curricula in all schools by qualified, capable teachers.

9. Federal Agencies —

OSHA — Congress' goal in enacting the 1970 Occupational Safety and Health Act was "to assure as far as possible every working man and woman in the nation safe and healthful working conditions . . ." This act created the Occupational Safety and Health Administration in the U.S. Department of Labor to set and to enforce mandatory safety and health standards. OSHA, unfortunately, is woefully understaffed. There is only one inspector for each several thousand workplaces. OSHA has primarily directed its attention to the more visible and sudden safety hazards and has not, by and large, addressed itself to the more chronic concerns of health hazards such as occupational carcinogenesis. OSHA is neither staffed with medical competence nor can it examine workers. It is constrained to look only at the industrial environ-

ment. The New Jersey experience with OSHA supports these contentions.

New Jersey may be able to augment OSHA's activity by calling for its increased funding. New Jersey must also make clear that the message is for more and vigorous activity in New Jersey, rather than a shying from delicate situations. As the New Jersey Cancer Control Program delineates carcinogenic exposures that must be eliminated, OSHA must be called on for enforcement. Failing an augmentation in OSHA's activity, a state program may have to be reinstituted.

NIOSH — National Institute for Occupational Safety and Health is a division of the Center for Disease Control, DHEW. Its primary responsibility is to establish, through research, occupational hazards that are to be controlled by OSHA. NIOSH has only research capability and no regulatory power. NIOSH also responds to requests by labor or management to investigate potential health hazards in the work place. NIOSH is staffed with five physicians to respond to Health Hazard Evaluation for the entire United States.

New Jersey's relationship to NIOSH is again two-fold. On the one hand, we must encourage proper funding so that NIOSH can adequately respond without unreasonable delay to Health Hazard Evaluation. On the other hand, NIOSH is a potential partner in demonstration programs of occupational health services that can be launched by the New Jersey Health Department's Cancer Control Program. They are not only a potential funding source, if their budget is adequate to respond to our requests, but also a source of consultation and expertise.

NCI — The National Cancer Institute has several missions. It not only conducts clinical treatment research and development, but also more basically, seeks to expose the etiology of cancer. For twenty years, the National Cancer Institute has explored infectious agents as potential causes of cancer. It has explored "biology gone wrong" at the molecular level. Their efforts have not been bent toward actually controlling cancer. If the NCI is to be a further partner with

New Jersey, their budget and program priorities must be re-examined.

Summary

The appalling statistics presented certainly give New Jersey the distinction as "Cancer-State-U.S.A." Why is New Jersey's cancer death rate so high for so many different types of cancer?

These statistics are merely the "tip-of-the-iceberg." How many of our citizens have undiscovered cancers and how many are being exposed on a daily basis to high levels of carcinogenic substances in the occupational setting and other environments?

These are the questions that must be answered if we are truly to control and to prevent cancer. Accurate information is essential, if we are to answer these questions. This information must be obtained through a registry of cancer patients as soon as they are diagnosed, not after they succumb of the disease. Also, we must pinpoint areas of the state where known carcinogenic substances are produced, used, stored, or given off as by-products to know what population groups are most at-risk.

Then, based upon this information, we can undertake vigorous ongoing epidemiologic investigations to answer essential questions. The information-gathering, epidemiologic studies, and education are the cornerstone of a *cancer prevention program*. When linked with screening, early diagnosis, treatment, and follow-up, these activities constitute a total *cancer control*

program. Such a program for New Jersey has been outlined.

Finally, no control program can be effective without *your* active interest and participation at the state, county, local and individual practitioner level!

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Publisher: The Medical Society of New Jersey
P.O. Box 904
Trenton, N.J. 08605

Advertising Representative: United Media Associates
16 Bruce Park Avenue
Greenwich, Conn. 06830
(203) 661-9702

General Information

Issuance:

Frequency: Monthly

Issue date: 10th of month.

Mailing date: 10th of month

Established: 1904

Organization Affiliation:

Official publication of
The Medical Society of New Jersey.

Circulation Data:

Controlled circulation to all members of The Medical Society of New Jersey. Members' subscription (\$5) is included in Society dues. Rates for non-members \$10, outside USA add \$2.50 for postage. Single copies \$1.

Annual percentage of subscription renewals:
90% of members.

Number of issues sent after subscription expiration: None.

Special Issues: Convention (April);
Annual Transactions (July or August);
Index (December)

Editorial Content: Original scientific articles, special articles, case reports, editorials, medical news, meeting notices, trustees' minutes, communicable disease reports, state legislation, convention, medical practice, PSRO, education, etc.

Requirements for Acceptance of New Professional Products for Advertising.
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Advertising is interspersed throughout the publication. All R.O.B. ads are rotated each month. Advertising and editorial material is not placed on the same page.

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14. Circulation:

All members of the Medical Society of New Jersey.

15. Guaranteed Circulation:

All members of the Medical Society of New Jersey.

16. Circulation Verification:

Publisher's statement, postal receipt verification.

17. Rates Per Thousand:

Based on the 12-times rate of \$220 and circulation of 10,000: \$22.00

THE JOURNAL of The Medical Society of NEW JERSEY

Rate Card effective January 1977

18. Coverage and Market

- a. Coverage: All members of The Medical Society of New Jersey, plus trade circulation of approximately 650 medical libraries, drug manufacturers, medical book publishers, medical abstract services, advertisers, advertising agencies, subscriptions. Circulation figures as of 10-1-76.
- b.
- | | |
|---------------|-------|
| GP | 2,991 |
| IM | 1,709 |
| GS | 1,314 |
| OBG | 741 |
| PED | 619 |
| DERM | 178 |
| ALL | 76 |
| UROL | 197 |
| EMT | 393 |
| PSYCH | 581 |
| OPH | 347 |
| RETIRED | 234 |
| TOTAL | 9,380 |
- c. Trade Circulation:
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1. Issuance:

Frequency: Monthly

Issue Date: 10th of month

Mailing date: 10th of month.

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Reservations: 1st of month preceding month of issue

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THE JOURNAL of The Medical Society of NEW JERSEY

Rate Card effective January 1977

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THE JOURNAL is printed by offset.

Trim size: 8 x 11

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1 full page	7 x 10
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½ vertical	3⅜ x 10
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1 full page	8⅛ x 11¼

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34. Paper Stock: Covers: 80-pound.

Inside pages: 60 pound.

35. Type of Binding: Perfect bound.

36. Halftone Screen: Up to 133 screen

37. Reproduction Requirements:

Black and white positives and 2-color advertisements: negatives, camera-ready mechanicals, and art work acceptable.

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b. Publication set copy: 5th of month preceding month of issue.

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Material is held for one year and then destroyed.

40. Addresses:

Contracts and insertion orders:

The Journal of The Medical Society of New Jersey
370 Morris Avenue
Trenton, N.J. 08611
609-393-7196

Reproduction material:

Journal of M.S.N.J.
Dartmouth Printing Company
69 Lyme Road
Hanover, N.H. 03755
603-643-2220

Sales, general information:

United Media Associates
16 Bruce Park Avenue
Greenwich, Connecticut 06830
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NEW JERSEY DOCTORS' NOTEBOOK

Professional Liability

Importance of Medical Records

(This item has been prepared by Myron J. Bromberg, Esq. for the Joseph A. Britton Agency, in accordance with a request from the Special Session of the House of Delegates 12/4/75 — see JMSNJ 73:166 (February) 1976.)

Medical records kept in the physician's office, as well as those kept in the hospital, are frequently the crucial items of proof in a professional liability action against a physician. Whereas records were previously kept for the sole purpose of permitting the medical personnel dealing with the patient to record what the prior condition and treatment of the patient had been, this aspect of practice takes on a new dimension in today's milieu, where, unfortunately, a patient must often be viewed as a potential adversary.

Details of the physician's treatment are, of course, carefully scrutinized in a malpractice case. The physician may have treated dozens, hundreds or perhaps thousands of patients subsequent to the event in question. He generally has no particular reason to remember what he observed, what he did or what he said. On the other hand, the patient has probably lived through only one such medical crisis or event and, because it is a major item in his life, juries expect that he would have a better recollection of the facts than the physician. Therefore, a physician's testimony that he has no recollection of the event and no record of it, but that he knows what he "usually" does in such a circumstance, is quite likely to be disbelieved in the face of the patient's contradictory testimony.

What can the physician do to deal with the problem? He must make an adequate record, recording dates of professional contacts with the patient (including telephone conversations) and covering history, physical examination and findings, treatment rendered, and medications prescribed including dosages and duration. In addition, if he provides the patient with special instructions, he should so note on his records. If

he warns the patient of possible side effects of a drug or follow-up laboratory tests which should be pursued, he should make a notation of this in his record.

Needless to say, the record should be legibly written — at least sufficiently legible so that he himself will be able to read it in the future. This, of course, makes common sense from a medical standpoint and is crucial from a legal standpoint.

It is also important that the physician note *negative findings*. This is not to suggest that every negative finding must be recorded, but at very least a general statement such as "all other findings normal" or "no other complaints" or "all other systems normal" takes a short time to write, but is invaluable when it is alleged that the physician neglected to make sufficient inquiries of the patient or neglected to perform a sufficiently thorough examination. Likewise, a note of "no known allergies" will be considerably more helpful before a jury than an absence of any comment whatsoever about allergies when a suit follows an untoward reaction to a drug.

Physicians frequently tell me that what is suggested above is impractical and unreasonably time consuming. I respectfully suggest that it is not, but is, in fact, an absolute necessity in today's medical practice. It requires self-discipline for a period of time until habit replaces the need for that rare trait.

None of the above should, however, encourage anyone to "create" or "improve" a record long after the event. Aside from the fact that such actions are dishonest, they have the unfortunate further quality of assuring the physician the loss of his malpractice suit. The fact of the matter is that most professionals are inept crooks and are invariably found out when they do such things. Aside from the fact that they lack the technical know-how of the forger or embezzler, panicked physicians often forget that by the time they attempt to make an addition or change in a hospital or medical record, the plaintiff's at-

torney has already obtained a copy of the same. This will provide the embarrassment of being faced with a copy of the record at the time of trial which lacks the "improvement." Imagine the task facing your attorney when he has not only to convince the jury that you are medically competent and acted properly, but that these things are so despite the fact that you lurked about the record room subsequent to the event, "laundering" the record.

The physician can ill-afford inadequate records in today's world. Methodical and thorough records are as necessary a part of his armamentarium as his medical skills.

211th Annual Meeting

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CMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President, CMDNJ

CMDNJ classes have resumed and 328 students began their studies at the Newark-based medical and dental schools, Rutgers Medical School, and the Graduate School of Biomedical Sciences, up 25 over last year's total of 1,096. Of these new students 37 (nearly all from New Jersey) are transfers from medical schools overseas into the third year class at New Jersey Medical School.

In addition, more than 150 other students have enrolled in the programs in the allied health professions which include midwifery, respiratory therapy, and other specialties; and 85 graduates of foreign medical schools have joined the Fifth

Pathway program. This summer the widely acclaimed programs for minority student preparation and orientation in medicine and dentistry received a three-year, \$264,592 continuation grant from the Robert Wood Johnson Foundation.

For professionals in practice, the College's Office of Continuing Education is embarking on new programming under the leadership of Dr. Mark Franklin, assistant vice president. A series of topics in internal medicine, October 10 and 24, and November 7 and 21, will be offered at co-sponsoring Bayonne Hospital. The subject of the first two sessions will be endocrinology, and of the latter two, infectious disease. Also on November 3 there will be a conference on "Lowering Cholesterol — The Why and How," at the Sheraton Heights Hotel, Hasbrouck Heights, sponsored by the New Jersey Medical School's Center for Coronary Risk Factor Control.

Following a multi-million dollar expansion program, the varied and specialized services of CMDNJ-Raritan Valley Hospital have projected its reputation to the entire state. It is, for example, becoming a major center for kidney transplantation. But it has not lost the personal, community nature that marks its service to a Middlesex-Somerset catchment area.

Mention should be made here of an event that took place in Washington, D.C. — the reversal by the U.S. Department of Health, Education and Welfare of a threatened dismemberment of New Jersey in the end-stage renal disease program. The original HEW plan was to assign the southern part of the state to a Philadelphia region and the northern part to New York.

A number of representatives from the College and others, including Senator Williams and Representatives Florio, Meyner, and McGuire, met with HEW and demonstrated that New Jersey actually was ahead of most other states in its coordination of renal disease treatment and that it was fully competent to take care of its own. The net result was that HEW announced it had changed its original plan to divide the country into 31 sectors. There would be 32, the 32nd being New Jersey.

Therapeutic Drug Information Center*

The Schwartz Inter-National Pharmaceutic and Therapeutic Drug Information Center of the Brooklyn College of Pharmacy, Long Island University, compiles the information contained in this column each month. The Center serves as a source of intelligence on therapeutic and pharmaceutical information not readily available to physicians, at no charge to them, and provides this information with minimal time involvement. It is staffed by trained pharmacists; Jack M. Rosenberg, Pharm. D., Associated Professor and Chairman, Division of Clinical Pharmacy, Brooklyn College of Pharmacy, is Director and Walter Modell, M.D., Emeritus Professor of Pharmacology at Cornell University Medical College, is pharmacologist consultant. The service is available Monday through Friday from 9 a.m. to 4:30 p.m. — telephone (212) 622-8989 or 636-7535. The following are questions and answers handled by the Center recently.

1. Do you have any information concerning the efficacy of short term low-dose therapy with metronidazole in the treatment of *Trichomonas vaginalis*?

Oral metronidazole (Flagyl®) remains the major recommended mode of therapy in the United States for the treatment of *Trichomonas vaginalis*,¹ despite recent reports of its mutagenic activity in bacteria and oncogenic activity in rodents.^{2,3} For the treatment of this condition, the current metronidazole package literature recommends that 7.5 grams be given orally in a dosage regimen of 250 mg three times daily over a period of ten days.^{4†} Investigations have demonstrated that lower doses given over shorter periods are highly effective in the treatment of trichomoniasis. It has also been suggested that single-dose therapy when compared to longer-term therapy may decrease the risk of carcinogenesis.⁵

In the United Kingdom the usual dosage of metronidazole for the treatment of *Trichomonas vaginalis* is 4.2 grams given as 200 mg three times daily for seven days.^{6,7} (Tablet strength available in the U. S. is 250 mg.)

McClean⁸ studied 200 female patients having their first infestations with *Trichomonas vaginalis*. These women were treated with a total dosage of 4 grams administered as 400 mg twice daily over a five-day period. After an initial follow-up, 181 (91.4 percent) of 198 women who finished their course of therapy apparently were cured. Eight of the 17, who were treatment failures or reinfected, responded to a repeat of the same dosage regimen. The other nine defaulted. The only adverse reaction reported was an urticarial rash in one patient whose treatment was then stopped.

Davidson⁷ studied 77 women who received 4 grams of metronidazole given over a period of two days. These women

were given 800 mg in the morning and 1200 mg at night. Thirty-eight consorts received similar therapy. A 94.8 percent cure rate was reported, which is similar to cure rates reported with the current recommended 10 day therapy.⁹ Of the four women who were treatment failures, three were thought to be reinfected. Nine patients complained of nausea and two complained of vomiting, one of whom washed her tablets down with vodka on an empty stomach. Other complaints included "furred tongue," a "feeling of influenza," and a feeling that the "tablets went through like a bomb." None of these adverse reactions prevented any patients from completing the therapy.

Dykens¹ treated 31 female patients who had trichomoniasis and their consorts with 2 grams of metronidazole given as one dose consisting of eight 250 mg tablets. No trichomonads were found on any of the follow-up visits during 18-72 hours after their dosage. One patient had recurrence of trichomoniasis 10 months after therapy. It was not determined whether this was uneradicated infection or reinfection. Five patients or consorts reported nausea or emesis, one in association with alcohol. Two patients reported headache and two reported having a bitter aftertaste.

Underhill and Peck¹⁰ treated 57 patients with trichomonal vaginitis using 200 mg of metronidazole three times daily for 7 days (Group A) and 69 patients using 2 grams as a single dose (Group B). They concluded that the 2 gram single dose course of therapy gave as good results as the standard seven-day course of treatment advocated in Great Britain.

In conclusion, it appears that in the treatment of trichomoniasis four grams of metronidazole given over two or five days, or two grams given as a single dose yield high cure rates. The low-dose short term therapy is economical and is likely to ensure better patient compliance. Furthermore, it has been suggested that a lower dosage given over a shorter period of time may be advantageous when using a drug which has been implicated as having oncogenic and mutagenic activity.^{5,11} However, the clinical effectiveness of low-dose, short-term therapy in comparison to current therapy needs further substantiation and any conclusive findings about metronidazole's role as a carcinogenic or mutagenic agent in humans may determine its future place in the treatment of trichomoniasis.

References

¹Dykens JR Jr: Single-dose metronidazole for trichomonal vaginitis. *Med Intel* 293:23, July 3, 1975.

*This month's column was prepared by J. M. Rosenberg, Pharm. D., P. Sangkachand, B.S., M.K. Raina, M. Pharm., Ph.D., and W. A. Simon, Pharm. D., Brooklyn College of Pharmacy, LIU.

†Since this was written the FDA recommended dose has been decreased to 250 mg three times daily for seven days for both females and their consorts. The new official labeling will also include a box warning which states, "Metronidazole has been shown to be carcinogenic in mice and possibly carcinogenic in rats (see warnings). Unnecessary use of the drug should therefore be avoided. Its use should be reserved for the conditions described in the indications' section."

Reference

Schmidt AM, Whitehorn WV, Martin EW: *FDA Drug Bulletin* 6:22-23 (Apr-May) 1976.

²Legator MS, *et al*: Detection of mutagenic activity of metronidazole and niridazole in body fluids of humans and mice. *Science* 188:1118, June 13, 1975.

³Anon.: *Med Let* 17:53, June 20, 1975.

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⁵Dykens JR Jr: Hazards of metronidazole. *N Engl J Med* 293:454 August 28, 1975.

⁶Anon.: *Martindale The Extra Pharmacopoeia*, 26th Edition. London, England, The Pharmaceutical Press, 1972, p. 1095.

⁷Davidson F: Short-term, high-dose metronidazole for vaginal trichomoniasis. *J Obstet Gynaecol Br Commonw* 80:368-370, April, 1973.

⁸McClellan AN: Treatment of trichomoniasis in the female with a 5-day course of metronidazole (Flagyl®). *Brit J Vener Dis* 47:36-37, February, 1971.

⁹Peterson WF, *et al*: Trichomonal vaginitis: Epidemiology and therapy. *Am J Obstet Gynecol* 97:472-478, February 15, 1967.

¹⁰Underhill RA, Peck JE: Causes of therapeutic failure after treatment of trichomonal vaginitis with metronidazole: Comparison of single-dose treatment with a standard regimen. *Br J Clin Pract* 28:134-136, April, 1974.

¹¹Personal Correspondence between Dr. Sidney M. Wolfe, Ms. Anita Johnson of Searle Laboratories, Washington, D.C. and Alexander M. Schmidt, M.D., Commissioner of Food and Drugs, Washington, D.C. Oct. 21, 1975.

2. Please supply information about the use of heparin in treating retained gallstones in the common bile duct.

Gallstones in the common bile duct or hepatic duct may be overlooked during biliary tract operations. The elimination of these retained stones, which for the most part contain cholesterol as the predominant component, poses a major problem for the surgeon. Various types of non-operative techniques have been sought to treat these retained stones. Usually, a T-shaped tube is put in the common bile duct and bile drained out. Various irrigating fluids like warm saline, sodium cholate, cetylpyridium chloride, ether, and chloroform have been used with varying degrees of success, with the hope of solubilizing and/or flushing out any retained stones. Heparin has also been tested as a chemical means of treating gallstones, since it has been postulated that heparin aids in the dispersion of suspended particles in the bile, thus preventing their agglomeration.

Gardner, *et al*¹ reported a case of retained common duct

stones treated with continuous infusion of heparinized saline (25,000 units of heparin in 250 ml of saline) through a T-tube. Disappearance of stones was seen in follow-up cholangiograms. Subsequently Gardner² published similar experiences on five additional patients. Using 25,000 units of heparin in 250 ml of saline given every eight hours in a continuous drip, Gardner and his group³ has reported success in thirty-one of the forty-three patients thus far treated. Neither cholangitis nor changes in clotting time occurred in any patient.

From another center, Patterson⁴ reported success in several cases, not only in common biliary duct stones but also in hepatic duct calculi. In this study, 20,000 units of heparin in 300 ml of saline were given every six hours. Cholangiograms showed that stones disappear in an average time of nine days.

Attempts to dissolve and/or fragment gallstones *in vitro* by incubating with heparinized saline or heparinized bile have been unsuccessful in the hands of certain investigators.^{5,6} However, Lahana, *et al*.⁷ found heparin to have definite effect on the fragmentation and/or dissolution of gallstones *in vitro*.

Considering the present data, it is too early to offer any judgment on this procedure. Whether the success *in vivo* is due to any chemical action of heparin or due to mechanical factors is still a matter of conjecture. More widespread, well-controlled studies are needed to determine the effectiveness of heparin in treating gallstones.

References

¹Gardner B, *et al*: Reappraisal of the possible role of heparin in solution of gallstones: A clinical extension of laboratory studies in removal of retained common duct stones. *Surgery* 69:854, 1971.

²Gardner B: Experiences with the use of intracholedochal heparinized saline for the treatment of retained common duct stones. *Ann Surg* 177:240, 1973.

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⁶Romero R and Butterfield WC: Heparin and gallstones. *Amer J Surg*. 127:687, 1974.

⁷Lahana DA, *et al*: Gallstone dissolution *in vitro* by bile acids, heparin, and quaternary amines. *Surg Gynecol Obstet* 138:683, 1974.

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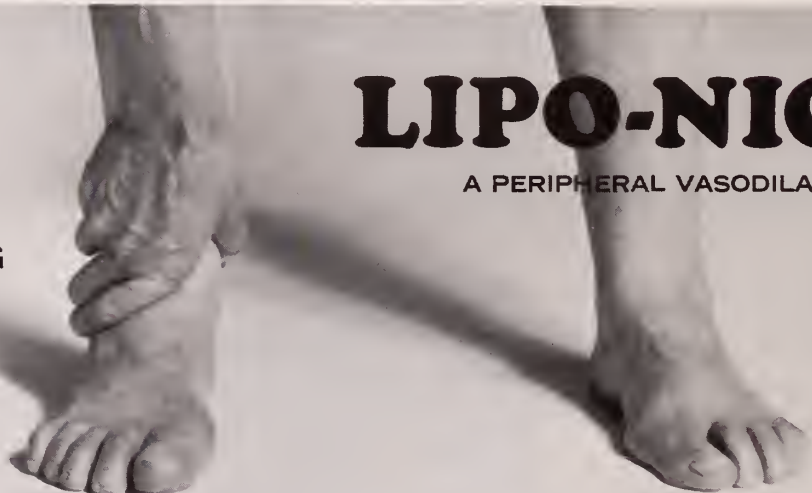
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PHYSICIANS SEEKING LOCATION IN NEW JERSEY

The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

FAMILY PRACTICE — Shiv N. Radtogi, M.D., 1641 Third Avenue, Apt. 12-E, New York 10028. S.N. Medical College, Agra (India). Also general surgery. Group, partnership, or solo. Available.

Harry Collins, M.D., 380 Maple Avenue West, Vienna, Virginia 22180. Hahnemann 1974. Board eligible. Group or ER in southern New Jersey. Available.

Jonathan B. Tocks, M.D., 1315 Strafford Road, Camp Hill, Pa. 17011. Michigan 1973. Group. Available July 1977.

Gary M. Cummins, M.D., 124 Oak Ridge Drive, York, Pa. 17400. Pittsburgh 1974. Board eligible. Available July 1977.

S. Osman, M.D., 10460 Curotte Avenue, Montreal, P.Q., Canada H2C 2Y7. Cairo 1968. Group or full-time emergency. Available.

GASTROENTEROLOGY — Robert D. Fusco, M.D., 1416 Wyldewood Road, Durham, North Carolina 27704. University of Pittsburgh 1973. Board eligible. Group or partnership. Available July 1977.

Tarig Butt, M.D., 33 Highland Street, Apt. 3-H, New Britain, Connecticut 06052. King Edward, Lahore (Pakistan) 1971. Board certified. Group, partnership, or solo. Available July 1977.

INTERNAL MEDICINE — Stephen Winograd, M.D., 208 Walnut Street, Montclair 07042. NYU 1972. Subspecialty, gastroenterology. Board certified. Solo, partnership, group. Available July 1, 1977.

Jeffrey I. Selwyn, M.D., 711 Pampa Place, Tucson, Arizona 85704. SUNY, Downstate 1972. Board certified. Group or partnership. Available January 1977.

Gene H. Ginsberg, M.D., 1735A Clarion Loop, Cannon AFB, Clovis, New Mexico 88101. Jefferson 1972. Board certified. Group, partnership or association, solo. Available July 1977.

Elihu J. Goren, M.D., 5509 Greentree Road, Bethesda, Maryland 20034. Einstein 1973. Subspecialty, endocrinology, Board eligible. Group or partnership. Available July 1977.

Fred H. Hyer, M.D., 6640 SW Fifth St., Pembroke Pines, Fla. 33023. CMDNJ 1970. Subspecialty,

rheumatology. Board eligible. Group, partnership, or solo. Available July 1977.

Joseph L. Verdirame, M.D., 200 Carman Ave., Apt. 6-G, East Meadow, New York 11554. Virginia 1974. Group. Available July 1977.

John S. Zesk, M.D., 56 Castleman Rd., Rochester, New York 14620. Rochester 1970. Subspecialty, cardiology. Board certified (IM). Group, clinic or partnership. Available July 1977.

Sudarshan K. Singal, M.D., 3737 Beaubien Street, Apt. 909, Detroit, Michigan 48201. Amritsar (India) 1969. Subspecialty, gastroenterology. Board certified. Any type practice. Available July 1977.

Mohammed Ashraf Sufi, M.D., 9587 Pickwick Circle East, Taylor, Michigan 48180. Dow, Karachi (Pakistan). Subspecialty, gastroenterology. Group, partnership, academic career. Available July 1977.

Donald Durham Volkmer, M.D., 24 Stoneland Road, Shrewsbury, Massachusetts 01545. Northwestern 1972. Board eligible. Partnership, small group. Available July 1977.

Leonard D. Ehrlich, M.D., 2200 Columbia Pike, Arlington, Virginia 22204. George Washington University. Subspecialty, gastroenterology. Board certified. Group or partnership. Available August 1977.

Geeta Mukhopadhyay Das, M.D., 140 North Broadway, Apt. L-4, Irvington, New York 10533. Royal College (England) 1972. Board eligible. Part-time group or hospital-based. Available.

Ashoke Kumar Das, M.D., 140 North Broadway, Apt. L-4, Irvington, New York 10533. Royal College (England) 1971. Board eligible. Group, partnership, solo, hospital-based salaried position. Available.

OCCUPATIONAL MEDICINE — Alexander A. Boytar, M.D., 3101 Skyline Dr., Wilmington De. 19808. Budapest, 1947. Board certified — (IM). Industrial medicine, pharmaceutical or chemical company, group of industrial physicians. Available.

OPHTHALMOLOGY — George R. Zambelli, M.D., 1353 Bradshire Road, Columbus, Ohio. St. Louis University. Board eligible. Solo, partnership, group. Available July 1977.

Edward B. Feinberg, M.D., 2819 Renfrew Avenue, Ann Arbor, Michigan 48105. Mt. Sinai 1971. Board eligible. Group, association, or partnership. Available July 1977.

PATHOLOGY — Azhar Saifuddin, M.D., Cambridge Arms Apts., Route 9, Box 644-A, Florence, Alabama 35630. Dow Medical College, Karachi (Pakistan) 1966. Board certified. Group, partnership, solo. Available.

Him G. Kwee, M.D., 207 Duke of York Lane, Apt. T-1, Cockeysville, Md. 21030. Airlangga (Indonesia) 1964. Group. Available July 1977.

PEDIATRICS — David Spiller, M.D., 401 East 86th Street, Apt. 11-K, New York 10028. New York Medical College 1972. Board eligible. Solo. Available.

Stewart Gabel, M.D., 5805 Tivoli Circle, Richmond, Virginia 23227. Albert Einstein 1968. Board eligible. Group or hospital setting. Available.

Mark B. Levin, M.D., 5100 Highbridge St., Apt. 505, Fayetteville, New York 13066. SUNY (Syracuse) 1974. Group, partnership, solo. Available July 1977.

Elizabeth W. Dow, M.D., 3705-B Woodmont Blvd., Nashville, Tenn. 37215. Vanderbilt 1972. Board eligible. Special interest in adolescence. Group, student health service, partnership, hospital. Available October 1, 1976.

Stephen Schlesinger, M.D., 2309 Tarleton Drive, Charlottesville, Virginia 22901. SUNY (Buffalo) 1970. Board certified. Any type practice. Available July 1977.

Robert Sasson, M.D., 142 Longmeadow Apartments, Cornwells Heights, Pennsylvania 19020. SUNY (Downstate). Board eligible. Group, partnership, or solo. Available July 1977.

RADIOLOGY — Benjamin Anthony Giella, Jr., M.D., Box 1316 Hopkinson House, Washington Square South, Philadelphia, Pennsylvania 19106. University of Pennsylvania 1970. Special interest — diagnostic radiology. Board eligible. Hospital, group, or partnership. Available July 1977.

Nanjappa C. Sadasivan, M.D., 16520 Schaefer Street, Apt. #7, Detroit, Michigan 48235. Stanley (India) 1969. Special interest — ultrasound and diagnostic radiology. Board eligible. Any type practice. Available July 1977.

SURGERY — Henry H. Bard, M.D., 10 Medical Plaza, Glen Cove, New York 11542. Columbia 1948. Board certified. Partnership, full time. Available.

David L. Walrath, M.D., 12 Polo Lane, Westbury, New York 11590. CMDNJ (Newark) 1970. Partnership or small group. Available July 1977.

UROLOGY — David H. Kauder, M.D., 4016 Grimes Avenue South, Edina, Minnesota 55416. SUNY, Downstate 1971. Board eligible. Group or partnership. Available June 1977.

Stephan Jay Sweitzer, M.D., 350 Curtin Drive, Lexington, Kentucky 40503. Vanderbilt University 1970. Board eligible. Group or association leading to partnership. Available July 1977.

Stanley M. Bernstein, M.D., 350 W. 57th St., Apt. 4-G, New York 10019. NYU 1968. Board eligible. Any type of practice. Available January 1977.

Syed S. Mada, M.D., 260-18 73rd Avenue, Glen Oaks, New York 11004. Punjab (Pakistan) 1967. Board eligible. Any type of practice. Available July 1977.

Steven Ross, M.D., 4469 Chestnut Ridge Road, Tonawanda, New York 14150. CMDNJ 1972. Board eligible. Group, partnership, or solo practice. Available July 1977.

Charles Bamberger, M.D., 2775 Bender Avenue, Akron, Ohio 44319. University of Chile 1969. Partnership or solo practice. Available July 1977.

211th Annual Meeting Haddon Hall — Atlantic City May 13-17

Tentative Daily Schedule

Friday

3:30 p.m. — Board of Trustees Meeting

Saturday

8:00 a.m. — Registration Opens

9:00 a.m. — Governor's Conference "Government and Medicine"

12:00 p.m. — Exhibits Open

12:00 p.m. — Golden Merit Award Ceremony and Reception

2:00 p.m. — Motion Picture Theatre

4:00 p.m. — House of Delegates

5:00 p.m. — Reference Committees (4)

7:30 p.m. — Cocktails, Dinner, Entertainment, Music, and Dancing — Cozy Morley Wing-ding and Bash

Sunday

8:00 a.m. — Registration Opens

8:30 a.m. — AMA Issues Workshop

9:00 a.m. — Exhibits Open

9:00 a.m. — Scientific Sessions

10:00 a.m. — Reference Committees (5)

10:00 a.m. — Motion Picture Theatre

12:00 p.m. — Luncheons

1:00 p.m. — Scientific Sessions

3:00 p.m. — House of Delegates (election)

4:30 p.m. — Widows and Orphans Meeting

6:30 p.m. — Inaugural Reception

8:00 p.m. — Inaugural Dinner Honoring President-Elect Begen

Monday

7:30 a.m. — JEMPAC Breakfast

8:30 a.m. — Registration Opens

9:00 a.m. — Exhibits Open

9:00 a.m. — Scientific Sessions

10:00 a.m. — Motion Picture Theatre

12:00 p.m. — Luncheons

1:00 p.m. — Scientific Sessions

2:00 p.m. — Motion Picture Theatre

3:00 p.m. — House of Delegates

3:30 p.m. — Exhibits Close

5:30 p.m. — JEMPAC Wine and Cheese Reception

8:00 p.m. — Annual Dinner-Dance (Entertainment)

Tuesday

9:00 a.m. — Registration Opens

9:00 a.m. — House of Delegates

12:00 p.m. — Registration Closes

3:00 p.m. — Board of Trustees

LETTER TO THE JOURNAL

CMDNJ Alumnus Speaks Out

July 29, 1976

Dear Dr. Krosnick,

I am an alumnus of the New Jersey College of Medicine, having graduated in 1969. I recently received a letter from Dr. Stanley Bergen, president of the college asking me to contribute to the Century Club of the Alumni Association. I felt compelled by his request to write to you expressing my thoughts as well as the thoughts of other alumni that I have spoken to concerning the direction the Medical School is taking.

Recently, in the past few weeks, there was a confrontation between minority medical students, the Concerned Citizens' Group of the City of Newark, and the administration of the Medical School concerning the failure of two medical students in their examinations. Much to my chagrin, the administration of the school gave in to the threats of the students and the Concerned Citizens' Group and had the students re-examined by a racially mixed group of examiners. The outcome of these actions is well known. I feel that these and other actions of the administrative staff of the New Jersey College of Medicine are disgraceful. The management of the minority students, both in the example mentioned above and others too numerous to mention, makes me ashamed to admit that I am an alumnus of the school. I have had personal experience as a resident teaching these students and I am fully aware of the pressures that can be applied when one tries to make an honest evaluation. I feel that they have allowed the academic standards of the school to diminish to an unacceptably low point and have established an unacceptable set of double standards allegedly to help the minorities. I personally feel this is an act of cowardice and is a manifestation of a lack of moral backbone. There is no conceivable reason why the medical profession already under attack on so many fronts should expose itself to further criticism by producing physicians of in-

ferior quality merely to satisfy a quota established by bureaucrats. It is equally as reprehensible to bow to the demands and threats of a medically uninformed concerned citizens' group. In my view and in the view of numerous alumni, these cowardly actions are a bastardization of the principles and very foundations of medicine, principles taught to me by the finest of instructors while I attended school only a few years ago.

Many of my thoughts were expressed brilliantly by you in your commentary in May of 1976 in *The Journal* of The Medical Society of New Jersey. I would at this time like to reinforce them and add a plea that President Bergen and the other administrators of the New Jersey College of Medicine return to the goals of academic excellence, a position that was once held by the institution from which I graduated. I believe that when they can find the courage to stand up to the elements that seem determined to destroy American medicine and begin to treat medical students as individuals rather than as quotas, they may expect vast numbers of alumni to rally to the support of the school in a manner appropriate to the dignity of an outstanding institution.

Paul Harper, M.D.

Miriam Nilis Armstrong

It is with great sorrow that we announce the death on July 26th of Miriam Nilis Armstrong, who was assistant editor of *The Journal* from March 1947 to March 1962. Mrs. Armstrong had been an employee of MSNJ in both the executive and editorial offices for eight years prior to that appointment.

ANNOUNCEMENTS

Course in Pediatric Clinical and Theoretical Allergy

In cooperation with the New Jersey Medical School, CMDNJ, the Children's Hospital of Newark is sponsoring a review course in clinical problems in pediatric allergy designed for pediatricians, family physicians, and allergists. The program runs from September through May. Lectures are held each Thursday from 11 a.m. to 12 noon in the Chapel Conference Room at United Hospitals of Newark. In addition a pediatric allergy clinic will be held from 8:30 to 10 a.m. on each of these days, and from 12 noon to 1 p.m. there will be a pediatric conference. Hour-for-hour credit will be awarded in Category I of the AMA Physician's Recognition Award. Tuition is \$100. For information, please address a communication to Arthur F. Fost, M.D., Director of Allergy, Children's Hospital of Newark, 15 South 9th Street, Newark 07107.

The schedule for October and November is as follows:

- Oct. 7 — Anaphylactic or Type I Reactions
- Oct. 14 — Mediators of the Allergic Reactions
- Oct. 21 — Immunodeficiency Disorders
- Oct. 28 — Pediatric Pulmonary Conference
- Nov. 4 — Evaluations of Immunology Reactions
- Nov. 11 — Pathophysiology of Asthma
- Nov. 18 — Pulmonary Function by Bronchspirometry

Psychiatric Association Sessions

The Tri-County Chapter of the New Jersey Psychiatric Association announces the following Fall programs:

- October 27 Psychic Phenomena and Psychiatry
Montague Ullman, M.D.
- December 8 Depressive Personality and Affect Reflected in
Dreams: A Basis for Psychotherapy
Walter Bonime, M.D.

The sessions convene at 6:30 p.m. at the Mayfair Farms, West Orange. Co-sponsor of the December meeting is the New Jersey Academy of Psychoanalysis. Two credit hours will be awarded in Category I of the AMA Physician's

Recognition Program. For further information, please communicate with Harvey Shwed, M.D., Secretary of the Chapter, 268 High Street, Newark 07102.

ACS Course on Trauma

From December 1 to 3 at the New York Biltmore, a seminar on trauma, designed for surgeons, interns, residents, and emergency medicine technicians, will be presented by the American College of Surgeons, Trauma Division. The course will offer a comprehensive program of continuing education in the definitive treatment of the seriously injured, and is designed to enhance the knowledge and skills of physicians who are first confronted with trauma patients. Curriculum will include such topics as pre-hospital care, approach to the severely injured patient, blood transfusions, monitoring the critically ill patient, management of cardiac emergencies, drug overdose, psychiatric emergencies, thoracic trauma, the burned patient, and pediatric emergencies.

The fee for surgeons is \$200; interns and residents, \$100; technicians, \$150. Registration is limited to 300 and forms are available from the American College of Surgeons, Trauma Division, 55 East Erie Avenue, Chicago, Illinois 60611 or from G. Thomas Shires, M.D., Department of Surgery, The New York Hospital-Cornell Medical Center, 525 East 68th Street, New York 10021.

Rhinoplasty, Otoplasty, Maxillofacial Surgery

On Wednesday evenings, January 5 through March 9, 1977, New York University Post-Graduate School will present CME programs in rhinoplasty, otoplasty, and maxillofacial surgery. Designed for otolaryngologists and physicians in related fields, especially those interested in traumatic, plastic, and reconstructive surgery, there will be illustrated lectures and discussions; surgical procedures will be demonstrated and carried out on cadavers; and clinical

and operative sessions will be presented at New York University Medical Center and Bellevue Hospital Medical Center. Tuition is \$600. Thirty credit hours will be awarded in AMA Category I of the Physician's Recognition Award. For information please write to the Office of the Associate Dean, Registration Department, New York University Post-Graduate Medical School, 550 First Avenue, New York, New York 10016.

Cardiac Symposium in Arizona

The American Heart Association, Arizona Affiliate, will sponsor a cardiac symposium at Scottsdale, Arizona, January 21 and 22, 1977. Registration deadline is January 14 and the fee for the two days is \$60 (\$35 for one day) which includes luncheon. Hotel accommodations must be made by December 21 (Mountain Shadows Resort Hotel, Scottsdale). Application has been made for 12 credit-hours in AMA Category I and in the AARP program. Program information and other details may be obtained from the American Heart Association, Arizona Affiliate, 1445 East Thomas Road, Phoenix, Arizona 85014.

Preceptorships for Practicing Physicians

The Medical College of Pennsylvania is offering continuing medical education programs designed to give the general practitioner and the specialist an opportunity to update his skills and learn new techniques. Courses are offered in anesthesiology, medicine, surgery, neurology, obstetrics-gynecology, pathology, pediatrics, psychiatry, and radiology. Each program is individually arranged, and hour-for-hour credit

will be awarded in Category I of the AMA. Prescribed credits (hour-for-hour) will be granted by the American Academy of Family Practice, and credit approval in the American College of General Practice will be given for up to 210 hours. For additional information, please communicate with Gerald H. Escovitz, M.D., Associate Dean for Medical Education, The Medical College of Pennsylvania, 3300 Henry Avenue, Philadelphia, Pennsylvania 19129.

Pediatric Ophthalmology Symposium

The Philadelphia Pediatric Ophthalmology Society, in conjunction with the Children's Hospital of Philadelphia, University of Pennsylvania, St. Christopher's Hospital for Children, Temple University, and Wills Eye Hospital, announces a symposium on pediatric ophthalmology, June 11 to 14, 1977 at the Cherry Hill Hyatt House. Topics to be covered include neuro-ophthalmology and strabismus; refraction and contact lenses; corneal diseases; complications in cataract surgery; plastic surgery; pharmacology and anesthesia; pediatric glaucomas; and retinal complications in childhood. The registration fee is \$175 and the three-day program has been granted 30 Category I credits toward the AMA Physician's Recognition Award. For additional information, please communicate with Harold P. Koller, M.D., Chairman of the Symposium, 1601 Spring Garden Street, Philadelphia 19130.

Training Program in Organizational Leadership

The American Academy of Medical Directors, in cooperation with the American Group Practice Foundation, has been awarded a three-year grant by the Robert Wood Johnson Foundation to train physicians for positions of organizational leadership. The program consists of two five-day courses conducted in eleven locations throughout the country. Purpose is to provide insights and skills of management necessary for such roles as chief medical executive, medical director, director of professional affairs, and the like. For information, please communicate with Mr. Roger S. Schenke, Project Director, "The Physician in Management," 20 South Quaker Lane, Alexandria, Virginia 22314.

Wanted: Herpes Simplex

Saint Michael's Medical Center is investigating the efficacy of anti-viral compounds in patients with recurrent herpes simplex. Physicians are requested to refer patients for this clinical research to: Leon G. Smith, M.D., Chief, Infectious Diseases Section, Department of Internal Medicine, Saint Michael's Medical Center, 306 High Street, Newark 07102.



RECENT CHANGES

federal register

**Providing
Drug Information
to Physicians**

**Informational
Bulletin #433-76**

**National
Health
Insurance**

special report
**Malpractice
insurance:**

**drug
bulletin**

**Health care doesn't
need more red tape**

**Drug firms challenge
'MAC' rules**

**Drug
Substitution**

**The Common Denominator
of Health Progress**
RESEARCH

Mailgram

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original FDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only the cost of the lowest-priced, purportedly-equivalent,

generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than \$1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005

POSTGRADUATE COURSE IN ACUPUNCTURE

by

New York Society of Acupuncture
for Physicians and Dentists, Inc.

at

New York University Medical Center

November 3-7, 1976

For application, please write:

Dr. S. J. Yue

115 East 61st Street

New York City, N.Y. 10021 or

phone mornings (212) 245-4737.

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APATHY • IRRITABILITY FORGETFULNESS • CONFUSION



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Nicotinic Acid	100 mg.
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AVAILABLE: Bottles 100, 500, 1000

SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and abdominal cramps. The reaction is usually transient.

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RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.

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CONTRAINDICATIONS: Epilepsy or low convulsive threshold.

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MEETINGS OF MEDICAL INTEREST

This listing is compiled through the cooperation of the Committee on Medical Education of The Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the College of Medicine and Dentistry of New Jersey. For information on accreditation, please contact the sponsoring organization(s).

Oct.

- | | |
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| <p>13 Management of Depression
1-2 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital)</p> <p>13 Thyroid Disease
1-3 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital)</p> <p>13 Management of the Violent Patient
1-2 p.m. — V.A. Hospital, Lyons
(Sponsored by Lyons V.A. Hospital)</p> <p>13 Current Treatment of Burns
1:30 p.m. — John E. Runnells Hospital, Berkeley Heights
(Sponsored by AMNJ and AAFP)</p> <p>13 Vasodilator Therapy in Chronic Heart Failure
9:30-11 a.m. — Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital)</p> <p>13 Cardiac Arrhythmias
1:30 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)</p> <p>13 Hyperparathyroidism and Vitamin D
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)</p> <p>13 Nephrolithiasis
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)</p> <p>13 Special Rounds, Obstetrics/Gynecology
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)</p> <p>13 Alienation in Adolescents
3-4:30 p.m. — Fair Oaks Hospital, Summit
(Sponsored by Fair Oaks Hospital)</p> <p>13 Management of Labor</p> <p>14 The Unconscious Patient</p> <p>15 Wound Care</p> <p>18 Visiting Professor Day</p> <p>19 Depression and Suicide, Part 2</p> <p>20 Transition at Birth</p> <p>21 Forearm and Wrist Fx</p> <p>22 Minor Surgery</p> <p>25 GU Tumors</p> <p>26 Plain Abdominal Film</p> <p>27 Toxemia of Pregnancy</p> <p>28 Pre-Natal Nutrition</p> <p>29 Anesthesia Machine and Compressed Gases
12 noon — Hunterdon Medical Center, Flemington
(Sponsored by Hunterdon Medical Center)</p> | <p>13 Thyroid Disease</p> <p>20 Medical Conditions Disguised as Dermatological Problems
1 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital)</p> <p>13 Coma in a Diabetic Patient</p> <p>20 Legal Medicine</p> <p>27 Cardiogenic Shock
10:30 a.m.-11:30 a.m. — Clara Maass Memorial Hospital, Belleville
(Sponsored by Clara Maass Memorial Hospital and AAFP)</p> <p>13 Joint Continuing Education Seminars
9:30-11:30 a.m. — Wednesdays until 6/22/77 — Riverside Hospital, Boonton
(Sponsored by Riverside, Dover General and St. Clare's Hospitals)</p> <p>13 Acquired Syphilis in Very Young
7:45-10 p.m. — 176 West Mt. Pleasant Avenue, Livingston
(Sponsored by The Journal Club of Greater Newark)</p> <p>14 Management of Uremic Patient
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)</p> <p>14 Oncogens and Oncogenesis
4-6 p.m. — Thursdays until 4/14/77 — Institute for Medical Research, Camden
(Sponsored by Institute for Medical Research)</p> <p>14 Mediators of the Allergic Reactions
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)</p> <p>15 Emotionally Disturbed Child
1:30-2:30 p.m. — Trenton Psychiatric Hospital
Neuroanatomy and Neuropathology
2:45-3:45 p.m. — Trenton Psychiatric Hospital
Clinical Neurology
4-5 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital)</p> <p>15 Emergency Medicine
12 noon — Freehold Area Hospital
(Sponsored by AMNJ and AAFP)</p> <p>15 Allergy
4:30 p.m. — Holiday Inn, Deepwater
(Sponsored by Salem County Medical Society, AMNJ and AAFP)</p> <p>16 Anesthesiology — Respiratory Care Symposium
8:30 a.m.-12:30 p.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital)</p> |
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- 16 **What's New in Diagnosis**
8 a.m.-5 p.m. — Stevens Institute of Technology, Hoboken
(Sponsored by Hudson County Medical Society and AAFP)
- 16 **Respiratory Care Symposium**
9 a.m.-1 p.m. — Rutgers Medical School, Piscataway
(Sponsored by N.J. State Society of Anesthesiologists)
- 18 **Neuroscience Lecture Series**
11:30 a.m.-12:30 p.m. — Mondays until 6/77 — Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital)
- 18 **Management of Hypertension**
1 p.m. — Ancora Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
- 19 **Oncology — Current Chemotherapy and Radiation**
12 noon — St. Mary's Hospital, Orange
(Sponsored by AMNJ and AAFP)
- 19 **Otoplasty**
6-10 p.m. — Pascack Valley Hospital, Westwood
(Sponsored by Bergen County Society of Otolaryngologists)
- 19 **Pulmonary Diseases**
9:30-10:30 a.m. — Every other Tuesday until 12/21/76 — South Amboy Memorial Hospital
(Sponsored by South Amboy Memorial Hospital)
- 20 **Rheumatoid Arthritis**
8:30 a.m.-3 p.m. — Rutgers Medical School
(Sponsored by Arthritis Foundation, N.J. Chapter, and New Jersey Rheumatism Assoc.)
- 20 **Drug Addiction**
1 p.m. — Trenton Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
- 20 **Proper Selection of Psychotropic Drugs**
9:30-11 a.m. — Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital)
- 20 **Fistula and Diaphragmatic Hernia**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
- 20 **Special Rounds, General Surgery and Specialties**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 20 **Antibiotic Therapy in Renal Disease**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 20 **Early Detection of Lung Cancer**
11:30 a.m.-12:30 p.m. — V.A. Hospital, East Orange
(Sponsored by East Orange V.A. Hospital)
- 20 **Medical Conditions Disguised as Dermatological Problems**
1-3 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital and AAFP)
- 20 **Halogenated Anesthetics**
8 a.m. — So. Ocean County Hospital, Manahawkin
(Sponsored by Burlington County Memorial Hospital and AAFP)
- 21 **Clinical Medical Ultrasound**
All day — Somerset Hospital
(Sponsored by AMNJ and AAFP)
- 21 **Immunodeficiency Disorders**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark)
- 21 **Non-Metastatic Complications of Carcinoma**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 21 **Psychiatric Aspects of Alcohol Abuse**
12 noon — Carrier Clinic, Belle Mead
(Sponsored by Merck, Sharp & Dohme)
- 22 **Psychodynamics and Psychotherapy of Psychiatric Disorders**
1:30-2:30 p.m. — Trenton Psychiatric Hospital
Neuroanatomy and Neuropathology
2:45-3:45 p.m. — Trenton Psychiatric Hospital
- 22 **Pediatric Post-Graduate Course**
9 a.m.-12 noon — Overlook Hospital
(Sponsored by Overlook Hospital and AAFP)
- 22 **Clinical Neurology**
4-5 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital)
- 24 **Physiology and Diseases of the Pituitary**
10-11 a.m. — Bayonne Hospital
Current Concepts in Diagnosis and Treatment of Thyroid Disease
11 a.m.-12 noon — Bayonne Hospital
(Sponsored by CMDNJ and Bayonne Hospital)
- 26 **Alcoholism**
12 noon — Hospital Center at Orange
(Sponsored by AMNJ and AAFP)
- 26 **Clinical Pathological Conference**
Every Tuesday, 10/26/76 to 10/25/77 — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital)
- 27 **Recent Advances in Para-Psychology and Its Application to Psychiatry**
8:30-10:30 p.m. — Mayfair Farms, West Orange
(Sponsored by New Jersey Psychiatric Association)
- 27 **Laboratory Interpretations**
3 p.m. — Fair Oaks Hospital, Summit
(Sponsored by AMNJ and AAFP)
- 27 **Coronary Artery Disease**
1:30 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
- 27 **Sexual Dysfunction**
9:30-11 a.m. — Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital)
- 27 **Lymphomas**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
- 27 **Dermatologic Manifestations of Internal Malignancy**
12 noon-1 p.m. — Englewood Hospital
(Sponsored by Englewood Hospital)

- 27 **Special Rounds, Internal Medicine**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 27 **Pancreatitis**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 27 **Management of Juvenile Diabetes**
10:30 a.m.-12 noon — Passaic General Hospital
(Sponsored by Hahnemann Medical College and AAFP)
- 27 **Depression: The Elusive Diagnosis**
1-5 p.m. — N.J. Medical School, Mental Health Center, Newark
(Sponsored by CMDNJ-N.J. Medical School)
- 28 **Endocrinological Disorders and Psychiatric Problems**
12 noon — Carrier Clinic, Belle Mead
(Sponsored by Carrier Clinic)
- 28 **Workshop on Hypertension**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 28 **Pediatric Pulmonary Conference**
11-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
- 29 **Psychodynamics and Psychotherapy of Psychiatric Disorders**
1:30-2:30 p.m. — Trenton Psychiatric Hospital
Neuroanatomy and Neuropathology
2:45-3:45 p.m. — Trenton Psychiatric Hospital
Clinical Neurology
4-5 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital)
- 29- **Clinical Heart Disease**
- 31 **Holiday Inn, Saddle Brook**
(Sponsored by St. Michael's Medical Center)
- 30 **Clinical Genetics — Update '76**
All Day — Morristown Memorial Hospital, Morristown
(Sponsored by Morristown Memorial Hospital)
- Nov.
- 1 **Proper Use of Antibiotics**
1 p.m. — Ancora Psychiatric Hospital, Hammonton
(Sponsored by AMNJ and AAFP)
- 1 **Lung Cancer**
8 p.m. — Community Memorial Hospital, Toms River
(Sponsored by AMNJ and AAFP)
- 1 **Visiting Professor Day**
- 2 **The Aged**
- 3 **Infant Feeding**
- 4 **Pelvis and Sacrum Injuries**
- 5 **Common Dermatology Problems**
- 8 **Hypertension**
- 9 **Corneal Disease**
- 10 **Bleeding in Pregnancy**
- 11 **Poisonings and Drug Overdose**
- 12 **Arterial and Venous Occlusions**
- 15 **Visiting Professor Day**
- 16 **Psychosis**
- 17 **Growth and Development-Mental and Emotional**
- 18 **Fx Knee and Lower Leg**
- 19 **Things Respiratory**
- 22 **GU Trauma**
- 23 **Esophagus and Stomach**
- 24 **Puerperium and Post Partum Care**
- 25 **Overweight and Obesity**
- 26 **Mechanical Bowel Obstruction**
- 29 **Visiting Professor Day**
- 30 **Marital Problems**
12 noon — Hunterdon Medical Center, Flemington
(Sponsored by Hunterdon Medical Center)
- 2 **Cardiac Rehabilitation**
11 a.m. — Greystone Park Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
- 3 **Clinical Endocrinology**
1 p.m. — Christ Hospital, Jersey City
(Sponsored by AMNJ and AAFP)
- 3 **Histocompatibility and the Recognition of Self**
9:30-11 a.m. — Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital)
- 3 **Selected Topics in Gastroenterology**
8-10 p.m. — Somerset Hospital
(Sponsored by N.J. Gastroenterology Society)
- 3 **Intraocular Lens Implantation**
5-8:30 p.m. — Hunterdon Medical Center, Flemington
(Sponsored by Hunterdon Medical Center)
- 3 **Acute Kidney Disease**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
- 3 **Mental Health Professionals and Lawyers — Allies or Adversaries**
8-10 p.m. — Seton Hall University, South Orange
(Sponsored by N.J. Psychiatric Association)
- 3 **Special Rounds, Pediatrics**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 3 **New Horizons in Diabetes**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 3 **Clinical Endocrinology**
- 10 **Total Parenteral Nutrition**
1 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital)
- 3 **Anti-arrhythmia Agents**
- 10 **Anti-arrhythmia Agents**
- 17 **Hyperlipidemia**
- 24 **Cardiovascular Applications of Nuclear Medicine**
10:30 a.m.-11:30 a.m. — Clara Maass Memorial Hospital, Belleville
(Sponsored by Clara Maass Memorial Hospital and AAFP)
- 3 **Cholesterol Lowering**
8:30 a.m.-4:30 p.m. — Sheraton Inn, Hasbrouck Heights
(Sponsored by CMDNJ and AAFP)

- 3 **Cardiopulmonary Resuscitation**
8:30 a.m.-4 p.m. — Rutgers Medical School
(Sponsored by CMDNJ and Kennedy Medical Center)
- 4 **Neurogenic Bladder**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 4 **Depression: A Social Psychiatric Overview**
12 noon — Carrier Clinic
(Sponsored by Carrier Clinic)
- 4 **Evaluations of Immunology Reactions**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
- 5 **Clinical Immunology**
8:30 a.m. — United Hospitals of Newark
(Sponsored by AMNJ and AAFP)
- 5 **Psychodynamics and Psychotherapy of Psychiatric Disorders**
1:30-2:30 p.m. — Trenton Psychiatric Hospital
Neuroanatomy and Neuropathology
2:45-3:45 p.m. — Trenton Psychiatric Hospital
Clinical Neurology
4-5 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital)
- 5 **Ischemic Heart Disease**
9-10 a.m. — St. Francis Medical Center, Trenton
(Sponsored by Hahnemann Medical College)
- 7 **Problems in Selecting an Antibiotic**
10-10:30 a.m. — Bayonne Hospital
Newer Antibiotics
10:30-11 a.m. — Bayonne Hospital
Immunoprophylaxis and Immunotherapy of Infectious Diseases
11 a.m.-12 noon — Bayonne Hospital
(Sponsored by CMDNJ and Bayonne Hospital)
- 9 **Hyperparathyroidism**
8 a.m. — Southern Ocean County Hospital, Manahawkin
(Sponsored by Burlington County Memorial Hospital and AAFP)
- 9 **High Risk Pregnancy, Diabetes and Infertility**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 9 **Bleeding Diseases**
8 p.m. — Paul Kimball Hospital, Lakewood
(Sponsored by AMNJ and AAFP)
- 9 **Proper Use of Blood Gases**
9 p.m. — Bayonne Hospital
(Sponsored by AMNJ and AAFP)
- 10 **Suicidology**
3 p.m. — Fair Oaks Hospital, Summit
(Sponsored by AMNJ and AAFP)
- 10 **Diagnosis of the Anemic Patient**
1:30 p.m. — Runnells Hospital, Berkeley Heights
(Sponsored by AMNJ and AAFP)
- 10 **Clinical Endocrinology**
1:30 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
- 10 **Contraception**
10:30 a.m.-12 noon — Passaic General Hospital
(Sponsored by Hahnemann Medical College and Hospital)
- 10 **Thyroid Disease**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
- 10 **Unstable Angina**
9:30-11 a.m. — Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital)
- 10 **Cor Pulmonale**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 10 **Special Rounds, Obstetrics — Gynecology**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 10 **Regional Meeting, American College of Physicians**
Alexander Hall, Princeton University
(Sponsored by ACP and NJSIM)
- 10 **Parenteral Nutrition — Hyperalimentation**
1-3 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital and AAFP)
- 10 **Annual Scientific Meeting, N.J. Chapter AAP**
1-5 p.m. and 8-9 p.m. — Ramada Inn, Clark
(Sponsored by N.J. Chapter, American Academy of Pediatrics)
- 11 **Pathophysiology of Asthma**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMNJ)
- 11 **Hyperbaric Oxygen in Decubitus Ulcers**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 11 **Thyroid Disorders**
12 noon — Carrier Clinic, Belle Mead
(Sponsored by Carrier Clinic)
- 12 **Psychodynamics and Psychotherapy of Psychiatric Disorders**
1:30-2:30 p.m. — Trenton Psychiatric Hospital
Neuroanatomy and Neuropathology
2:45-3:45 p.m. — Trenton Psychiatric Hospital
Clinical Neurology
4-5 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital)
- 12 **Psychoanalytic Psychophysiological Model for Chemotherapy of Psychosomatic Illness**
8:30-10:30 p.m. — Hackensack Hospital
(Sponsored by N.J. Psychoanalytic Association)
- 13 **Diagnosis and Prevention of Sports Injuries**
9 a.m.-12 noon — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital)

- 16 **Problems in a Student Health Service**
7:45-10 p.m. — 561 So. Orange Avenue, So. Orange
(Sponsored by the Journal Club of Greater Newark)
 - 16 **Oncology — Breast and Lung Cancer**
12 noon — St. Mary's Hospital, Orange
(Sponsored by AMNJ and AAFP)
 - 17 **Shock**
1 p.m. — Trenton Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
 - 17 **Hepatitis B Immune Globulin in Hepatitis B Infections**
9:30-11 a.m. — Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital)
 - 17 **Effect of Age on the Response to Cardio-Active Agents**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
 - 17 **Arthroscopy**
8 a.m. — Southern Ocean County Hospital, Manahawkin
(Sponsored by Burlington County Memorial Hospital and AAFP)
 - 17 **Bullae, Blebs, Cysts: Surgical Considerations**
11:30 a.m.-12:30 p.m. — V.A. Hospital, East Orange
(Sponsored by East Orange V.A. Hospital)
 - 17 **Intestinal Absorption and Malabsorption**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
 - 17 **Special Rounds, General Surgery and Specialties**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 17 **Neurosurgical Treatment of Pain**
1-2 p.m. — V.A. Hospital, Lyons
(Sponsored by Lyons V.A. Hospital)
 - 18 **Pulmonary Function by Bronchspirometry**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
 - 18 **Dermal Ulcers and Necrotic Burns**
12 noon-1 p.m. — St. Mary's Hospital, Orange
(Sponsored by St. Mary's Hospital)
 - 18 **Interstitial Nephritis**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
 - 18 **Diabetes Mellitus**
12 noon — Carrier Clinic, Belle Mead
(Sponsored by Carrier Clinic)
 - 18 **Uses and Abuses of Estrogen Therapy**
5-6:30 p.m. — Somerset Hospital, Somerville
(Sponsored by Somerset Hospital)
 - 18 **Regional Chest Conference**
7:30-9:30 p.m. — Martland Hospital, Newark
(Sponsored by New Jersey Thoracic Society)
 - 19 **Gastrointestinal Bleeding**
12 noon — Freehold Area Hospital
(Sponsored by AMNJ and AAFP)
 - 19 **Clinical Endocrinology**
4:30 p.m. — Holiday Inn, Deepwater
(Sponsored by Salem County Medical Society, AMNJ and AAFP)
 - 19 **Psychodynamics and Psychotherapy of Psychiatric Disorders**
1:30-2:30 p.m. — Trenton Psychiatric Hospital
Neuroanatomy and Neuropathology
2:45-3:45 p.m. — Trenton Psychiatric Hospital
Clinical Neurology
4-5 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital)
 - 21 **Review of Pneumonia**
10-10:30 a.m. — Passaic General Hospital
Common Mistakes in Bacteriology Laboratories
10:30-11 a.m. — Passaic General Hospital
Fever of Unknown Origin
11 a.m.-12 noon — Passaic General Hospital
(Sponsored by Hahnemann Medical College)
 - 23 **Dermatology**
12 noon — Hospital Center at Orange
(Sponsored by AMNJ and AAFP)
 - 23 **Psychopathology of Sexual Dysfunction**
2-4 p.m. — Camden County Psychiatric Hospital
(Sponsored by Camden County Psychiatric Hospital)
 - 24 **Occupational Medicine**
3-4:30 p.m. — Fair Oaks Hospital, Summit
(Sponsored by Fair Oaks Hospital)
 - 24 **Hyperlipemia, 1976**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
 - 24 **Special Rounds, Internal Medicine**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 24 **Clinical Immunology**
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
 - 24 **Rheumatoid Disease**
9:30-11 a.m. — Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital)
 - 24 **Mycosis Fungoides and Relevant Skin Lymphomas**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
 - 24 **Laparoscopy**
12 noon-1 p.m. — Englewood Hospital
(Sponsored by Englewood Hospital)
 - 24 **Management of the Hypertensive Patient**
10:30 a.m.-12 noon — Passaic General Hospital
(Sponsored by Hahnemann Medical College)
- Dec.**
- 1 **Swine Flu — 1976**
9:30-11 a.m. — Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital)
 - 1 **Clinical Immunology**
1 p.m. — Christ Hospital, Jersey City
(Sponsored by AMNJ and AAFP)

- 1 **Hypoglycemia As a Clinical Problem**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
- 1 **Advances in Nutrition**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 1 **Special Rounds, Pediatrics**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 1 **Management of Diabetes Mellitus**
1:30-2:30 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital)
- 1 **Selected Topics in Gastroenterology**
8-10 p.m. — Overlook Hospital, Summit
(Sponsored by N.J. Gastroenterology Society)
- 2 **Urinary Tract Infection**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 2 **Update in Psychopharmacology**
12 noon — Carrier Clinic, Belle Mead
(Sponsored by Carrier Clinic)
- 2 **Blood Gases**
11-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
- 3 **Surgical Management of Ulcerative Colitis**
8:30 a.m. — United Hospitals of Newark
(Sponsored by AMNJ and AAFP)
- 3 **Psychodynamics and Psychotherapy of Psychiatric Disorders**
1:30-2:30 p.m. — Trenton Psychiatric Hospital
- 3 **Neuroanatomy and Neuropathology**
2:45-3:45 p.m. — Trenton Psychiatric Hospital
Clinical Neurology
4-5 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital)
- 4 **Surgical Scientific Sessions**
9 a.m.-4:30 p.m. — CMDNJ-Rutgers Medical School
(Sponsored by N.J. Chapter, ACS)
- 6 **Laboratory Interpretations**
1-3 p.m. — Ancora Psychiatric Hospital, Hammonton
(Sponsored by AMNJ and AAFP)
- 6 **Alcoholism**
8 p.m. — Community Memorial Hospital, Toms River
(Sponsored by AMNJ and AAFP)
- 7 **Congestive Heart Failure**
11 a.m. — Greystone Park Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
- 8 **Chronic Renal Failure**
1:30 p.m. — Runnells Hospital, Berkeley Heights
(Sponsored by AMNJ and AAFP)
- 8 **Emergency Medicine**
1-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
- 8 **Hormones and Cancer**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
- 8 **Screening for Colon Cancer**
9:30-11 a.m. — Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital)
- 8 **Philosophical Background of Transactional Analysis, Part I**
3-4:30 p.m. — Fair Oaks Hospital, Summit
(Sponsored by Fair Oaks Hospital)
- 8 **Psychoactive Medications**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 8 **Special Rounds, Obstetrics — Gynecology**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 9 **Diagnosis and Management of GI Bleeding**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 9 **PSRO: Psychiatry's Situation Remains Obscure**
12 noon — Carrier Clinic, Belle Mead
(Sponsored by Carrier Clinic)
- 9 **Hyperlipidemia**
5-6:30 p.m. — Somerset Hospital, Somerville
(Sponsored by Somerset Hospital)
- 9 **Definitions of Asthma**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
- 14 **Hematuria and Its Causes**
8 a.m. — Southern Ocean County Hospital, Manahawkin
(Sponsored by Burlington County Memorial Hospital and AAFP)
- 14 **Burns**
8 p.m. — Paul Kimball Hospital, Lakewood
(Sponsored by AMNJ and AAFP)
- 14 **Thyroid Diseases**
9 p.m. — Bayonne Hospital
(Sponsored by AMNJ and AAFP)
- 14 **Vaginal Surgery**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 15 **Infectious Disease in a Community Hospital**
1-3 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital)
- 15 **Complications of Alcoholism**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 15 **Hypersensitivity and Immunity**
11:30 a.m.-12:30 p.m. — V.A. Hospital, East Orange
(Sponsored by East Orange V.A. Hospital)

- 15 **Special Rounds, General Surgery and Specialties**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 15 **Psychiatric Aspect of Endocrine Disorders**
1 p.m. — Trenton Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
 - 15 **Prolapse of the Mitral Valve**
9:30-11 a.m. — Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital)
 - 15 **Facial Trauma and Reconstructive Surgery**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
 - 16 **Inhalation Therapy and O₂ and Mist Therapy**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
 - 16 **Low Back Pain**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
 - 17 **Bleeding Diseases**
12 noon — Freehold Area Hospital
(Sponsored by AMNJ and AAFP)
 - 21 **Infectious Diseases**
12 noon — St. Mary's Hospital, Orange
(Sponsored by AMNJ and AAFP)
 - 21 **Chronic Renal Failure**
12 noon — Hospital Center at Orange
(Sponsored by AMNJ and AAFP)
 - 22 **Gastrointestinal Bleeding**
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
 - 22 **Computerized Tomography**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
 - 22 **When to Refer to the Geneticist**
9:30-11 a.m. — Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital)
 - 22 **Headaches in Children**
8 a.m. — Southern Ocean County Hospital, Manahawkin
(Sponsored by Burlington County Memorial Hospital and AAFP)
 - 22 **Philosophical Background of Transactional Analysis, Part II**
3-4:30 p.m. — Fair Oaks Hospital, Summit
(Sponsored by Fair Oaks Hospital)
 - 22 **The Aging Heart**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
 - 22 **Special Rounds, Internal Medicine**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 23 **Pediatric Pulmonary Conference**
11-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
 - 29 **Clinical Pathology Conference**
9:30-11 — Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital)
 - 30 **Hospital Management of Childhood Asthma**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
- 1977
Jan.
- 3 **Diagnosis and Treatment of Shock**
1 p.m. — Ancora Psychiatric Hospital, Hammonton
(Sponsored by AMNJ and AAFP)
 - 3 **Pacemakers**
8 p.m. — Community Memorial Hospital, Toms River
(Sponsored by AMNJ and AAFP)
 - 4 **Coronary Artery Disease**
11 a.m. — Greystone Park Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
 - 5 **Cancer Research**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
 - 5 **Special Rounds, Pediatrics**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 5 **Emergency Medicine**
1 p.m. — Christ Hospital, Jersey City
(Sponsored by AMNJ and AAFP)
 - 5 **Clinical Endocrinology**
3 p.m. — Fair Oaks Hospital, Summit
(Sponsored by AMNJ and AAFP)
 - 5 **Fiberoptic Bronchoscopy**
9:30-11 a.m. — Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital)
 - 5 **Myasthenia Gravis**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
 - 5 **Selected Topics in Gastroenterology**
8-10 p.m. — Medical Center, Princeton
(Sponsored by N.J. Gastroenterology Society)
 - 6 **The Allergic Child**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
 - 6 **Workshop on Hypertension**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
 - 7 **Indications for Cardiac Surgery in Rheumatic and Congenital Heart Disease**
8:30 a.m. — United Hospitals of Newark
(Sponsored by AMNJ and AAFP)

- 11 **Pre-Hospital Coronary Care**
8 p.m. — Paul Kimball Hospital, Lakewood
(Sponsored by AMNJ and AAFP)
 - 11 **Sports Medicine**
9 p.m. — Bayonne Hospital
(Sponsored by AMNJ and AAFP)
 - 11 **Abnormal Pap Smear in Young Woman**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
 - 12 **Weakness and Fatigue**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
 - 12 **Special Rounds, Obstetrics — Gynecology**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 12 **Clinical Immunology**
11:30 a.m. — Rahway Hospital
(Sponsored by AMNJ and AAFP)
 - 12 **Surgery in Ulcerative Colitis**
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
 - 12 **Endocrine Diseases of the Male and Female Gonads**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
 - 13 **Chronic Chest Disease in Children**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMNJ)
 - 13 **Chronic Pulmonary Obstructive Disease**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
 - 18 **Endotoxic Shock**
12 noon — St. Mary's Hospital, Orange
(Sponsored by AMNJ and AAFP)
 - 19 **Hepatitis**
1 p.m. — Trenton Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
 - 19 **Acid Base Disturbances**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
 - 19 **Out-Patient Management of COPD**
11:30 a.m.-12:30 p.m. — V.A. Hospital, East Orange
(Sponsored by East Orange V.A. Hospital)
 - 19 **Pathophysiology of Anemia**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
 - 19 **Special Rounds, General Surgery and Specialties**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 20 **Asthma**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
 - 20 **Sex Therapy — Non-Orgasmic Female**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
 - 20 **Immunologic and Pathophysiological Aspects of Asthma**
5-6:30 p.m. — Somerset Hospital, Somerville
(Sponsored by Allergy Society)
 - 21 **Sex Therapy — Impotent Male**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
 - 21 **Clinical Immunology**
12 noon — Freehold Area Hospital
(Sponsored by AMNJ and AAFP)
 - 21 **Bleeding Diseases**
4:30 p.m. — Holiday Inn, Deepwater
(Sponsored by Salem County Medical Society, AMNJ and AAFP)
 - 25 **Child Abuse and Neglect**
8 p.m. — Warren Hospital, Phillipsburg
(Sponsored by AMNJ and AAFP)
 - 26 **Hepatitis**
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
 - 26 **Malignant Melanomas**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
 - 26 **Gram Negative Infections in Surgery**
9-11 a.m. — Auditorium, Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
 - 26 **Special Rounds, Internal Medicine**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 27 **Pediatric Pulmonary Conference**
11-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
- Feb.
- 1 **Pre-Hospital Coronary Care**
11 a.m. — Greystone Park Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
 - 2 **Laboratory Interpretations**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
 - 2 **Special Rounds, Pediatrics**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 2 **Gastrointestinal Bleeding**
1 p.m. — Christ Hospital, Jersey City
(Sponsored by AMNJ of New Jersey and AAFP)
 - 2 **Gout and Pseudogout**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
 - 3 **Hypersensitivity Pneumonitis**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)

- 3 **Low Renin Hypertension**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 4 **Laboratory Interpretations**
8:30 a.m. — United Hospitals of Newark
(Sponsored by AMNJ and AAFP)
- 7 **Coronary Artery Disease**
1 p.m. — Ancora Psychiatric Hospital, Hammonton
(Sponsored by AMNJ and AAFP)
- 7 **Vascular Surgery**
8 p.m. — Community Memorial Hospital, Toms River
(Sponsored by AMNJ and AAFP)
- 8 **Cerebral Vascular Disease**
8 p.m. — Paul Kimball Hospital, Lakewood
(Sponsored by AMNJ and AAFP)
- 8 **Acute Renal Failure**
9 p.m. — Bayonne Hospital
(Sponsored by AMNJ and AAFP)
- 8 **Ovarian Tumors**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 9 **Genetic Counseling**
1-3 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital)
- 9 **Management of Hepatitis**
11:30 a.m. — Rahway Hospital
(Sponsored by AMNJ and AAFP)
- 9 **Current Chemotherapy**
1:30 p.m. — Runnells Hospital, Berkeley Heights
(Sponsored by AMNJ and AAFP)
- 9 **Fluid and Electrolyte Imbalance**
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
- 9 **Hyperaldosteronism**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
- 9 **Common Intestinal Parasites**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 9 **Special Rounds, Obstetrics — Gynecology**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 10 **Aeroallergens, Air Pollutants and Respiratory Disease**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
- 10 **Renal Transplantation**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 15 **Thyroid Disease**
12 noon — St. Mary's Hospital, Orange
(Sponsored by AMNJ and AAFP)
- 15 **Anesthetic Air Pollution in the Operatory**
8:30 p.m. (preceded by dinner at 6 p.m.) — Fireside Inn, Rochelle Park
(Sponsored by Dental Section, AMNJ)
- 16 **Thanatology**
3 p.m. — Fair Oaks Hospital, Summit
(Sponsored by AMNJ and AAFP)
- 16 **The Violent Patient**
1 p.m. — Trenton Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
- 16 **Congestive Heart Failure**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
- 16 **Clinical Physiology of the Control of Breathing**
11:30 a.m.-12:30 p.m. — V.A. Hospital, East Orange
(Sponsored by East Orange V.A. Hospital)
- 16 **Psychosomatic Problems in Children**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 16 **Special Rounds, General Surgery and Specialties**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 17 **Molds and Pollens**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
- 17 **Contact Dermatitis**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 17 **Cardiovascular Aspects of Jogging**
5-6:30 p.m. — Somerset Hospital, Somerville
(Sponsored by Somerset Hospital)
- 18 **Sports Medicine**
4:30 p.m. — Holiday Inn, Deepwater
(Sponsored by Salem County Medical Society, AMNJ and AAFP)
- 18 **Blood Gases**
12 noon — Freehold Area Hospital
(Sponsored by AMNJ and AAFP)
- 22 **Current Treatment of Burns**
8 p.m. — Warren Hospital, Phillipsburg
(Sponsored by AMNJ and AAFP)
- 23 **Breast Cancer**
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
- 23 **Adolescent Medicine**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
- 23 **Common Pediatric Orthopedic Problems**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 23 **Special Rounds, Internal Medicine**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)

24 Pediatric Pulmonary Conference
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)

24 Preservation of Ischemic Myocardium
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)

Mar.

1 Fluid and Electrolyte Imbalance
11 a.m. — Greystone Park Psychiatric Hospital
(Sponsored by AMNJ and AAFP)

2 Infertility
1 p.m. — Christ Hospital, Jersey City
(Sponsored by AMNJ and AAFP)

2 Fluid and Electrolyte Imbalance
11:30 a.m. — Rahway Hospital
(Sponsored by AMNJ and AAFP)

2 Coagulopathies and Dysproteinemia: Multiple Myeloma and Waldenstroms
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)

2 Child Health
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)

2 Special Rounds, Pediatrics
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)

2 Selected Topics in Gastroenterology
8-10 p.m. — Valley Hospital, Ridgewood
(Sponsored by N.J. Gastroenterology Society)

3 Diagnosis of Rhinitis
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)

3 Bypass Grafts
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)

4 Renal Transplantation
8:30 a.m. — United Hospitals of Newark
(Sponsored by AMNJ and AAFP)

4 Community Psychiatry
1:30-2:30 p.m. — Trenton Psychiatric Hospital

11 Neuroanatomy and Neuropathology
2:45-3:45 p.m. — Trenton Psychiatric Hospital

18 Clinical Neurology
4-5 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital)

7 Immunology
8 p.m. — Community Memorial Hospital, Toms River
(Sponsored by AMNJ and AAFP)

8 Cortical Steroid Therapy
8 p.m. — Paul Kimball Hospital, Lakewood
(Sponsored by AMNJ and AAFP)

8 Clinical Endocrinology
9 p.m. — Bayonne Hospital
(Sponsored by AMNJ and AAFP)

9 Obstructive Lung Disease
1:30 p.m. — Runnells Hospital, Berkeley Heights
(Sponsored by AMNJ and AAFP)

9 Current Chemotherapy, Breast Cancer
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)

9 Management of Patients in Diabetic Coma
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)

9 Disorders of Biliary Tract and Pancreas
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)

9 Special Rounds, Obstetrics — Gynecology
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)

10 Perennial Allergic Rhinitis, Vasomotor Rhinitis and Serous Otitis Media
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)

10 Use and Abuse of Dialysis
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)

15 Hematology-Diagnosis of Anemia
12 noon — St. Mary's Hospital, Orange
(Sponsored by AMNJ and AAFP)

16 Bronchial Asthma
11:30 a.m.-12:30 p.m. — V.A. Hospital, East Orange
(Sponsored by East Orange V.A. Hospital)

16 Physical Medicine in Office Practice
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)

16 Special Rounds, General Surgery and Specialties
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)

16 Thyroid Diseases
1 p.m. — Trenton Psychiatric Hospital
(Sponsored by AMNJ and AAFP)

16 Current Advances in Cancer Management
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)

17 Drug Therapy of Upper Respiratory Allergy
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)

17 Family Counseling
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)

17 Management of Angina
5-6:30 p.m. — Somerset Hospital, Somerville
(Sponsored by Somerset Hospital)

- 18 **Headache**
12 noon — Freehold Area Hospital
(Sponsored by AMNJ and AAFP)
 - 22 **Echo-Cardiography**
8 p.m. — Warren Hospital, Phillipsburg
(Sponsored by AMNJ and AAFP)
 - 22 **Pacemakers**
12 noon — Hospital Center at Orange
(Sponsored by AMNJ and AAFP)
 - 23 **Current Radiation Therapy, Breast Cancer**
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
 - 23 **Arthritis**
11:30 a.m. — Rahway Hospital
(Sponsored by AMNJ and AAFP)
 - 23 **Neurological Diagnosis**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
 - 23 **Special Rounds, Internal Medicine**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 23 **Virology and Interferon**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
 - 24 **Pediatric Pulmonary Conference**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
 - 24 **Marriage Counseling**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
 - 25 **Community Psychiatry**
1:30-2:30 p.m. — Trenton Psychiatric Hospital
Psychology
2:45-3:45 p.m. — Trenton Psychiatric Hospital
Forensic Psychiatry
4-5 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital)
 - 26 **Athletic Injuries**
9 a.m. — Valley Hospital, Ridgewood
(Sponsored by Valley Hospital)
 - 30 **Hepatitis**
3 p.m. — Fair Oaks Hospital, Summit
(Sponsored by AMNJ and AAFP)
 - 30 **Aortic Valvular Disease**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital, and AAFP)
 - 30 **Respiratory Virus Infections**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
 - 31 **Diagnosis and Treatment of Headache**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- Apr.
- 1 **Community Psychiatry**
1:30-2:30 p.m. — Trenton Psychiatric Hospital
Psychology
2:45-3:45 p.m. — Trenton Psychiatric Hospital
Forensic Psychiatry
4-5 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital)
 - 1 **Proper Use of Antibiotics**
8:30 a.m. — United Hospitals of Newark
(Sponsored by AMNJ and AAFP)
 - 4 **Orthopedic Problems**
8 p.m. — Community Memorial Hospital, Toms River
(Sponsored by AMNJ and AAFP)
 - 5 **Headache**
11 a.m. — Greystone Park Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
 - 6 **Parkinson's Disease and Related Disorders**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
 - 6 **Special Rounds, Pediatrics**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 6 **Selected Topics in Gastroenterology**
8-10 p.m. — St. Michael's Medical Center, Newark
(Sponsored by N.J. Gastroenterology Society)
 - 7 **Hyperlipedemia**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
 - 12 **Review and Update of OB/GYN**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
 - 12 **Collagen Disease**
8 p.m. — Paul Kimball Hospital, Lakewood
(Sponsored by AMNJ and AAFP)
 - 12 **Echo-Cardiography**
9 p.m. — Bayonne Hospital
(Sponsored by AMNJ and AAFP)
 - 13 **Proper Use of Blood Gases**
1 p.m. — Christ Hospital, Jersey City
(Sponsored by AMNJ and AAFP)
 - 13 **Current Surgical Techniques, Breast Cancer**
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
 - 13 **Headache**
11:30 a.m. — Rahway Hospital
(Sponsored by AMNJ and AAFP)
 - 13 **Cardiac Complications of Antidepressant Drugs and Major Tranquilizers**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
 - 13 **Special Rounds, Obstetrics — Gynecology**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)

- 14 **Review Symposium — Malpractice**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
 - 14 **Drug Allergy**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
 - 15 **Community Psychiatry**
 - 22 **1:30-2:30 p.m. — Trenton Psychiatric Hospital**
Mental Deficiency
2:45-3:45 p.m. — Trenton Psychiatric Hospital
Forensic Psychiatry
4-5 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital)
 - 15 **Scanning**
12 noon — Freehold Area Hospital
(Sponsored by AMNJ and AAFP)
 - 19 **Cardiac Arrhythmias**
12 noon — St. Mary's Hospital, Orange
(Sponsored by AMNJ and AAFP)
 - 20 **Child Abuse and Neglect**
1 p.m. — Trenton Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
 - 20 **Pulmonary Pathology in Connective Tissue Disease**
11:30 a.m.-12:30 p.m. — V.A. Hospital, East Orange
(Sponsored by V.A. Hospital, East Orange)
 - 20 **New Cardiac Drugs**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
 - 20 **Special Rounds, General Surgery and Specialties**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 21 **Insect Allergy**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
 - 21 **Carcinoma of Lung**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
 - 21 **Diagnostic Approaches to the Ischemic Lower Extremity**
5-6:30 p.m. — Somerset Hospital, Somerville
(Sponsored by Somerset Hospital)
 - 26 **Endotoxic Shock**
12 noon — Hospital Center at Orange
(Sponsored by AMNJ and AAFP)
 - 26 **Gastrointestinal Bleeding**
8 p.m. — Warren Hospital, Phillipsburg
(Sponsored by AMNJ and AAFP)
 - 27 **Emotional Crises in Practice**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
 - 27 **Special Rounds, Internal Medicine**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 27 **Lung Cancer**
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
 - 28 **Pediatric Pulmonary Conference and Case Presentations**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
 - 28 **Use and Abuse of Diuretics**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- May
- 2 **Emergency Medicine**
8 p.m. — Community Memorial Hospital, Toms River
(Sponsored by AMNJ and AAFP)
 - 3 **Cerebral-Vascular Disease**
11 a.m. — Greystone Park Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
 - 4 **Thanatology**
1 p.m. — Christ Hospital, Jersey City
(Sponsored by AMNJ and AAFP)
 - 4 **Sports Medicine**
11:30 a.m. — Rahway Hospital
(Sponsored by AMNJ and AAFP)
 - 4 **Low Back Pain**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
 - 4 **Special Rounds, Pediatrics**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 5 **Veterinary Allergy**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
 - 5 **Fluid and Electrolyte Balance**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
 - 6 **Proper Use of Blood Gases**
8:30 a.m. — United Hospitals of Newark
(Sponsored by AMNJ and AAFP)
 - 10 **Leukemia**
8 p.m. — Paul Kimball Hospital, Lakewood
(Sponsored by AMNJ and AAFP)
 - 10 **Plastic Surgery**
9 p.m. — Bayonne Hospital
(Sponsored by AMNJ and AAFP)
 - 11 **Thanatology**
1:30 p.m. — Runnells Hospital, Berkeley Heights
(Sponsored by AMNJ and AAFP)
 - 11 **Obstructive Lung Disease**
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
 - 11 **Sputum Examination**
11:30 a.m.-12:30 p.m. — V.A. Hospital, East Orange
(Sponsored by East Orange V.A. Hospital)

- 11 **Patient with Advanced Cancer**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 11 **Special Rounds, Obstetrics — Gynecology**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 12 **Urticaria and Angioedema**
11 a.m.-12 noon — United Hospitals of Newark,
(Sponsored by Children's Hospital of Newark and CMDNJ)
- 12 **Immunology and Asthma**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 17 **Tuberculosis**
12 noon — St. Mary's Hospital, Orange
(Sponsored by AMNJ and AAFP)
- 18 **What's New in Office Gynecology?**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 18 **Special Rounds, General Surgery and Specialties**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 19 **Atopic Dermatitis**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
- 19 **Outpatient Management of Pulmonary Tuberculosis**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 19 **Cellular Engineering in Medicine**
5-6:30 p.m. — Somerset Hospital, Somerville
(Sponsored by Somerset Hospital)
- 20 **Diabetes**
12 noon — Freehold Area Hospital
(Sponsored by AMNJ and AAFP)
- 24 **Thanatology**
12 noon — Hospital Center at Orange
(Sponsored by AMNJ and AAFP)
- 24 **Bleeding Diseases**
8 p.m. — Warren Hospital, Phillipsburg
(Sponsored by AMNJ and AAFP)
- 25 **Proper Use of Blood Gases**
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
- 25 **Headache**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 25 **Special Rounds, Internal Medicine**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 26 **Pediatric Pulmonary Conference and Case Presentations**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)

- 26 **Preventative Measures in Heart Disease**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)

June

- 1 **T.B. — Outpatient Treatment**
1 p.m. — Christ Hospital, Jersey City
(Sponsored by AMNJ and AAFP)
- 1 **Special Rounds, Pediatrics**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 2 **Pulmonary Function Tests**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 3 **Psychiatry-Medical Surgical Emergencies**
8:30 a.m. — United Hospitals of Newark
(Sponsored by AMNJ and AAFP)
- 6 **Non-Specific Urethritis**
8 p.m. — Community Memorial Hospital, Toms River
(Sponsored by AMNJ and AAFP)
- 7 **Arthritis**
11 a.m. — Greystone Park Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
- 8 **Special Rounds, Obstetrics — Gynecology**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 8 **Endotoxic Shock**
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
- 9 **Proper Use of Blood Gas**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 14 **Endocrine Changes in Menopause**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 14 **Pacemakers**
8 p.m. — Paul Kimball Hospital, Lakewood
(Sponsored by AMNJ and AAFP)
- 14 **Allergy**
9 p.m. — Bayonne Hospital
(Sponsored by AMNJ and AAFP)
- 15 **Adult Respiratory Distress Syndrome**
11:30 a.m.-12:30 p.m. — V.A. Hospital, East Orange
(Sponsored by East Orange V.A. Hospital)
- 15 **Special Rounds, General Surgery and Specialties**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 16 **Duodenal Ulcer Disease**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 16 **Current Concepts of Addiction**
5-6:30 p.m. — Somerset Hospital, Somerville
(Sponsored by Somerset Hospital)



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The Old Helping Hand Organization

Many of the younger doctors do not know that there exists in our state a unique helping hand organization, known as the Society for the Relief of the Widows and Orphans of Medical Men in New Jersey. This organization provides immediate financial assistance

to the dependents of a deceased member. It lends money without interest to assist widows and orphans of doctors who have known adversity.

For details, write to the Society at P.O. Box 102, Hopewell, New Jersey 08525.

OBITUARIES

Dr. Luther S. Bradley

One of Burlington County's senior members, Luther S. Bradley, M.D., of Mount Holly, died on July 20. Dr. Bradley was a native of North Carolina and received his undergraduate degree from Temple University and his doctorate in medicine from the Medical School of Howard University in 1928. Following internship in Philadelphia, he came to Mount Holly to practice general medicine and served the people in that area until his retirement in 1974.

Dr. Edmund W. Burroughs

After a long illness, Edmund W. Burroughs, M.D., a renowned Mercer County surgeon, died on June 12 at The Mercer Medical Center where he had been affiliated all of his professional life. Born in 1905 and graduated from the University of Pennsylvania School of Medicine in 1931, Dr. Burroughs was board certified in surgery and was a Fellow of the American College of Surgeons. He practiced in Trenton and had been on the surgical staff at The Mercer Medical Center there for many years, until retirement to Vero Beach, Florida, in 1972. During World

War II he was on active duty in the Medical Corps of the U. S. Army. His brother, Dr. Charles Burroughs, is a practicing physician in Trenton.

Dr. Jacob D. Katz

On July 17, Jacob D. Katz, M.D., died at his home following a long illness. A native of New York City, Dr. Katz earned his medical degree from St. Andrews University in Scotland in 1934 and pursued graduate study in urology, becoming board certified in that specialty. He was also a Fellow of the American College of Surgeons and a member of the American Urological Association. Dr. Katz had staff appointments at Jersey City Medical Center (where he was chairman of the department of urology), and at Christ, Pollak, Fairmount, and Margaret Hague Hospitals in Jersey City. He had been associate professor at Seton Hall Medical School. Dr. Katz was 67 years old at the time of his death.

Dr. John S. Leary

At the untimely age of 54, John S. Leary, M.D., a member of our Bergen County component, died on July 13. Dr. Leary received his medical degree from Tufts University School of Medicine in 1954 and pursued a residency in radiology at the University of Illinois Hospital. Upon completion he accepted an appointment as

the Associate Director of Radiology at Hackensack Hospital, a position he still held at the time of his death. Dr. Leary was board certified in his chosen specialty.

Dr. Charles O. Leff

Charles O. Leff, M.D., a senior member of our Essex County component, died on July 26. Born in 1899, Dr. Leff was graduated from the medical school at Northwestern University in 1926 and after a brief career in general medicine took graduate work in radiology, earning board certification in that field. He was a Fellow of the American College of Radiology and of the American Geriatrics Society. Dr. Leff maintained offices in South Orange and had been affiliated formerly with St. Barnabas Medical Center in Livingston and the New York Polyclinic Hospital.

Dr. Clifford B. Matthews

Word has just been received of the death on June 26, of Clifford B. Matthews, M.D., of Tenafly. A graduate of Temple University School of Medicine in 1933, Dr. Matthews practiced general medicine in Trenton for five years and industrial medicine in Newark until 1959, when he pursued a three-year residency in anesthesiology at New York Polyclinic Medical School. He was associated in that field in several New York hospitals and at Bergen Pines County Hospital in Paramus, and more recently at the Letchworth Village State School in Thiells, New York. Dr. Matthews was a member of the American and New Jersey Societies of Anesthesiology. He was 66 years old at the time of his death.

Dr. James H. Mooney

A prominent neurosurgeon in the Princeton-New Brunswick area, James H. Mooney, M.D., died suddenly on August 6 at Princeton Medical Center of an apparent heart ailment. A native of Pittsburgh, Dr. Mooney received his premedical and medical education at the University of Pittsburgh, earning his doctorate of medicine in 1953. After internship he took residencies in general and neurosurgery at Mercy Hospital in Pittsburgh, becoming board certified in the

latter. He practiced in Kingsport, Tennessee, before coming to New Jersey in 1962. Dr. Mooney was currently chief of neurosurgery at St. Peters Medical Center in New Brunswick and at the Princeton Medical Center. He was also on the staff at the Somerset Hospital in Somerville and the Raritan Valley Hospital in Greenbrook. Dr. Mooney was a Fellow of the American College of Surgeons, and a member of the Congress of Neurological Surgeons, the American Association of Neurological Surgeons, and the Society of Surgeons of New Jersey. He was only 51 years old at the time of his death.

Dr. Pierre J. Nyvall

On August 1, Pierre J. Nyvall, M.D., a general practitioner in Ocean County for forty years, died at Burlington County Memorial Hospital. Dr. Nyvall was graduated from the University of Minnesota School of Medicine in 1935 and did graduate work at George Washington University. He was on the staff at Paul Kimball Hospital in Lakewood and the Community Hospital in Toms River, and was a member of the American Academy of Family Practice. Dr. Nyvall had a term as President of the Ocean County Medical Society and had been active in civic affairs, having been school physician for Union, Ocean, and Lacey Townships and a member of the Board of Health of Union Township. He was 65 years old at the time of his death.

Dr. Thurlow H. Pelton

Thurlow H. Pelton, M.D., a retired urologist, residing in Mantoloking, died at his home on July 22. Born in 1907 and a graduate of Harvard Medical School, class of 1934, Dr. Pelton had taken a residency in urology at Columbia-Presbyterian Hospital in New York and pursued further graduate study at Berne, Switzerland. He was board certified in his chosen field. He practiced in Pittsfield, Massachusetts until moving to New Jersey in 1968. Recently Dr. Pelton had been on the staff at the Rutgers University Student Health Center and had been practicing general medicine in Whiting. He was a member of the Ocean County Medical Society, having transferred from the Berkshire District Medical Society of which he had been

President. Dr. Pelton had been on the active staff in seven hospitals in the Pittsfield and North Adams, Massachusetts areas. He was a Fellow of the American College of Surgeons and of the American Urological Association.

Dr. Mortimer Reich

One of Essex County's senior members, Mortimer Reich, M.D., who practiced in Irvington, died at his home in Short Hills on July 30. A graduate of the University of Pennsylvania School of Medicine in 1934, Dr. Reich pursued a career in urology, becoming board certified in that field. He was a Fellow of the American College of Surgeons and a member of the prestigious New Jersey Society of Surgeons. He had been on the attending staff in the department of urology at Irvington General, St. Barnabas Medical Center in Livingston, Martland, Beth Israel, and Crippled Children's hospitals in Newark, and Kessler Memorial Hospital in West Orange, where he also was chief of the department. Dr. Reich was 68 years old at the time of his death.

Dr. Joseph F. Velluzzi

One of Bayonne's well-remembered practitioners, Joseph F. Velluzzi, M.D., died on July 11 at Point Pleasant Hospital. Born in 1904 and graduated from the University of Rome College of Medicine in 1931, Dr. Velluzzi practiced general medicine for over forty years and had been on the staff at Bayonne Hospital for nearly as long. During World War II he had served in the Army Medical Corps in both the European and Pacific theaters of operation.

Dr. Margaret M. Wurts

Margaret M. Wurts, M.D., who formerly practiced general medicine in Upper Montclair, died on July 26 at Meadow Lakes, Hightstown, where she lived after retirement in 1970. Dr. Wurts received her doctor of medicine degree from Cornell Medical School in 1923 and came first to Englewood to practice. She had been on the staff at Mountainside Hospital in Montclair for many years, and was also a member of the faculty at Montclair State Teachers' College.

BOOK REVIEWS

Current Pediatric Diagnosis and Treatment. C. Henry Kempe, Henry K. Silver, Donough O'Brien. Los Altos, California, Longe, 1976. Pp. 1053. (Price \$15.00)

This handsome and soft-covered 4th edition utilizes 48 authors, primarily from the University of Colorado Medical Center, to bring the reader practical, up-to-date and essential pediatric knowledge. It offers nurses, students, and primary care physicians a complete review of pediatric diseases, and although not as complete as some of the older standard pediatric texts, contains a wealth of material and references. The contents are carefully subdivided for easy reading with important bibliographies interspersed after main topics within each chapter. The typography is well organized.

By design a book of this type cannot have many illustrations or pictures but many fine reference tables are presented. For this reason an older and experienced practitioner will find more merit in its content. With the current talk of recertification, it will be of value also for pediatric board members.

One would have to say that the authors successfully have completed an updated pediatric text, inexpensive, devoid of fine print, but competitive with other books of this nature. Congratulations.

Frank C. Vanore, M.D.

Safeguarding the Public Health, Newark, 1895-1918. Stuart Gollishoff. Westport, Connecticut, Greenwood Press, 1975. (Price not given)

Here is a charming and informative, well-documented, small volume describing a "pivotal period" in the history of public health science and service as it applied to Newark, "the nation's unhealthiest city," at the time. Many historical community and medical figures of Newark are recalled and their efforts, both productive and obstructive of the common good, are illuminated. Although admittedly a volume of limited scope, the author's detailed accounting of many of the factors which resulted in high morbidity and mortality of Newark's citizens is provocative. Patterns of disease, environmental forces, professional training and skills, societal concerns and activities may differ today from yesterday but there exists an analogy here that is stimulating to those who recognize and are considering the announced prefatory threads of this volume: increasing governmental assumption of responsibility for health and the interaction of medicine and society.

One only wishes that the author had progressed a few years farther into Newark's health history for there are still physicians alive today who witnessed, experienced, and contributed to the momentous changes in health care in Newark and in New Jersey. One also appreciates more that failure to learn the lessons of history condemns society to the repetition of the errors in the past. This is an enjoyable volume of medical history most pertinent for today's health professional.

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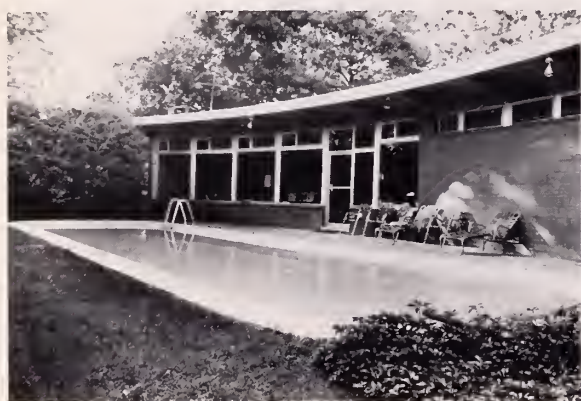
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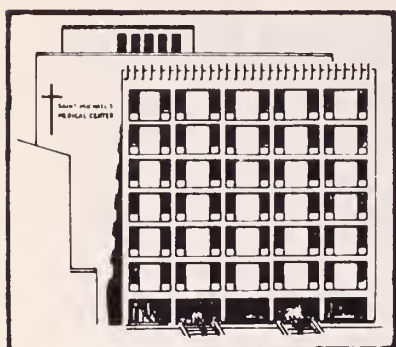
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WRITE FOR REPRINT: R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and Female Climacteric. *Drug Therapy*, Sept. 1976.

Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25

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avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpubertal cryptorchism, 30 mg. **REFERENCE:** Robert B. Greenblatt, M.D., and D. H. Perez, M.D.: "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Published monthly (since 1904), under direction of the Committee on Publication, by The Medical Society of New Jersey, 315 West State St., Trenton, N.J. Printed in Hanover, New Hampshire by the Dartmouth Printing Co. Whole number of issues 867. Member's subscription (\$5) is included in Society dues. Rates for nonmembers, \$10; outside USA add \$4 for postage. Single copies, \$1. Address communications to *The Journal*, MSNJ, P.O. Box 904, Trenton, N.J. 08605 (609) 394-3154. Second class postage paid at Trenton, N.J. and additional entry office. Copyright 1976 by The Medical Society of New Jersey.



November 1976

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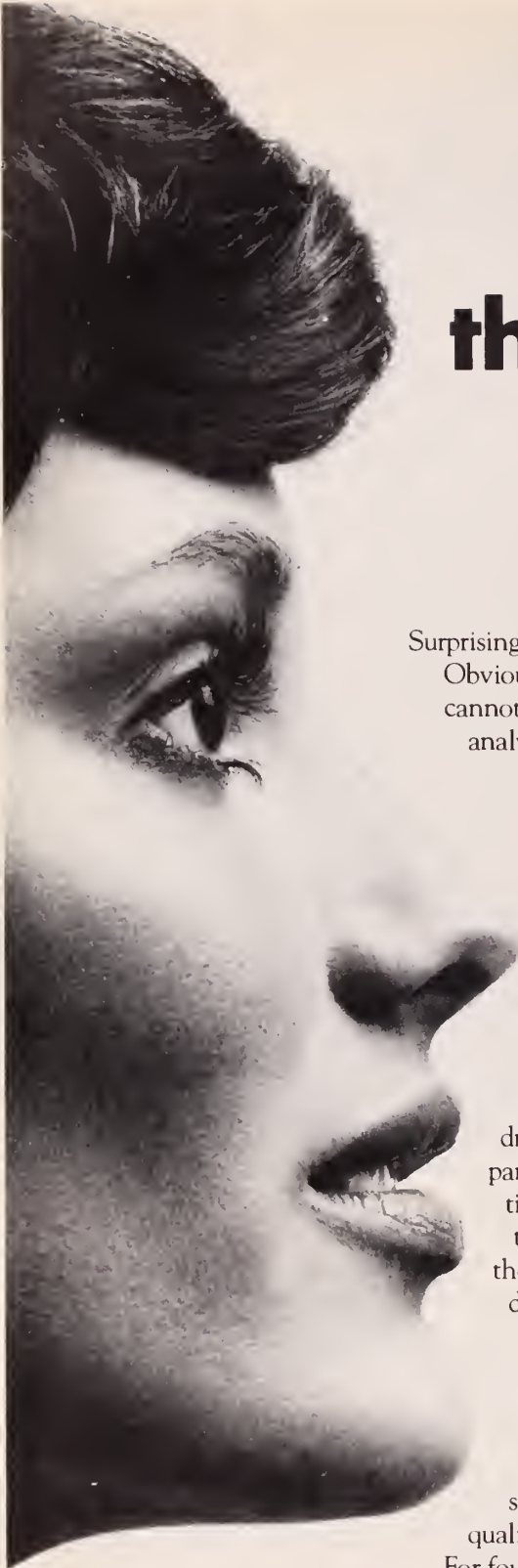
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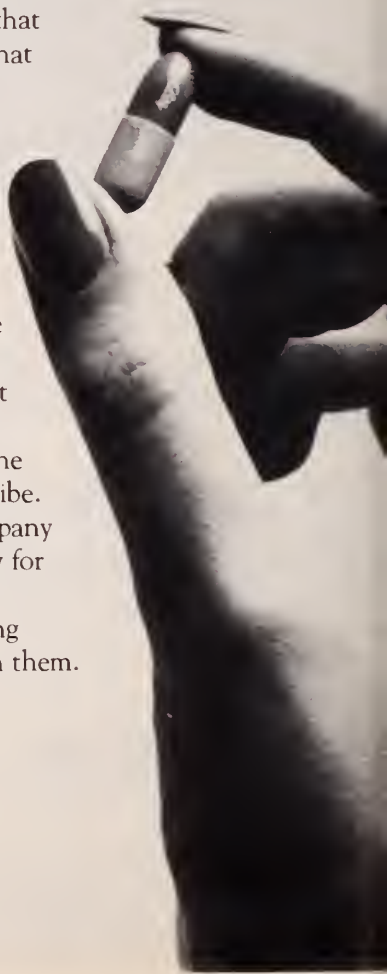
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EDITORIALS

Contracting in Patient Education

"Contracting" is a new approach to patient education in which the health care team and the diabetic list, in written agreement, the tasks that each must complete in a teaching program designed to bring about good control of the diabetic condition. Too often in the past — whether a diabetic, an obese patient, or a cardiac — patients had an attitude which said: "Teach me — I dare you to try!"

The essence was an intrinsic resistance to any slight modification in life style, which requires effort and sacrifice on the part of the patient. Physicians and other health educators often have given lip-service to patient education when, in truth, what they were seeking was patient compliance.

In this day of medical-legal riskology, physicians must be aware of their potential responsibility for patient problems which may result from patient ignorance. For example, the diabetic who takes an intermediate-acting insulin before breakfast in the morning, finishes work at five o'clock in the afternoon, and faces a one-hour auto trip home is in danger of a hypoglycemic reaction while driving. If his physician failed to warn him of this, did not instruct him to take a late afternoon snack and carry some rapidly-absorbed carbohydrate in his car, the patient ultimately may blame a tragic result on the doctor. Far-fetched? Not in this day and age!

The contract approach to patient education has merit. For one thing, it clearly spells out to the patient that he has a *responsibility* to learn and to incorporate the knowledge into his daily routine of self-management. The miserable world record of weight reduction of obese patients attests to the total failure of so-called

diet instruction based on a one-way street. The printed diet which is never read and never followed never does any good.

The paper in this issue by Morreau and one by Williams, which will appear in December, deal with contracting and patient education. The concept is applicable to all types of educational content including self-breast examination, avoidance of electromagnetic interference (E.M.I.) by the demand pacemaker patient, interactions between prescribed drugs, over-the-counter drugs, and certain foods, and almost every other patient-determined positive or avoidance action with potential health consequences. Physicians might consider developing their own patient education contract — a defensive measure which could rival informed consent in importance. A.K.

"Life Month"

November is the nineteenth "Life Month" for our original Life Plan with the Nationwide Life Insurance Company. Over \$3,000,000 has been paid to beneficiaries under this plan. Since each unit of insurance provides \$10,000 of death protection with double indemnity in case of accidental death, as well as a guaranteed conversion provision and a waiver of premium provision without extra charge, this represents over 300 units of insurance that have provided funds to beneficiaries.

Inflation has made increased insurance protection a necessity. Our low-cost, non-cancellable plan makes it easier for members to provide adequately for their families, especially since issuance has been simplified and in many cases applicants no longer need physical examinations.

A special "Life Month" mailing was made this month by our administrator, who will be happy to provide help and information as to the best uses of the total program for your circumstances. Look for your application in the mail. David Blanksteen

Motivation by Fear

At a recent meeting dealing with public service announcements concerning health, the director of a large public relations firm was asked, "What stimulates an individual to sit down and write out a check to a voluntary health agency?" Without a moment of hesitancy — even for essential blepharospasm — he responded, *Fear!*" The success of this phenomenon can be confirmed quite readily by a review of the incomes of the American Cancer Society and the American Heart Association. The technique is exemplified by their daily commercial messages (e.g., the ACS voice which refuses a proffered cigarette with, "No thanks, I can live without it.").

The *science* of persuasion (as opposed to the centuries-old *art* of persuasion) is relatively new¹. Can one motivate individuals to accept a beneficial, albeit new, painful, costly, or even potentially dangerous health practice through the use of scientific persuasion? Evidence points to the fact that one can do so as long as he meets certain criteria.

A study of 182 seniors at Yale University² was designed to present information on tetanus in pamphlet form to the students and to evaluate its effect on their behavior. Special booklets were prepared with a variable fear level of the message, an inconstant report as to effectiveness of inoculation and a spectrum of painfulness of the injection. Thus, the low-fear communication described tetanus as difficult to contract and easy to cure; the high-fear leaflet described tetanus as easy to contract and difficult to cure. Each was accompanied by a "case study," including more or less frightening photographs. A "control" pamphlet omitted the fear message. Inoculation was described as generally effective to almost perfect as a preventive against tetanus; "painfulness" of the injection was said to be ex-

treme in some pamphlets, but pain was entirely omitted from the discussion in others.

A questionnaire and follow-up evaluation of University Health Service inoculation records were revealing. The injection-taking behavior was not influenced by the reputed effectiveness or painfulness of the inoculation. However, the students exposed to the *high-fear* communication expressed a greater desire to be inoculated — and actually sought the injection — than those receiving the low-fear communication.

Scientists in the psychology of persuasion are quick to point out that the effectiveness of strong vs. mild fear depends on the individual situation under consideration. Strong fear is more effective as a behavior modifier when it poses a threat to the subject's loved ones, when it originates from a highly credible source, when it deals with a topic which is unfamiliar to the person, and when it is aimed at persons with a high degree of self-esteem and/or a low perception of vulnerability to danger. They go on to suggest that "fear appeals" are most likely to change behavior when (1) the recipient of the message can take immediate action on recommendations in the message and (2) specific instructions are provided for carrying out those recommendations in the appeal.¹

Thus, physicians can use fear to stimulate their patients to change their health or life-style behavior patterns. However, this technique must be used scientifically, wisely, and — like the tiger-handler says — "very carefully."

¹Karlin M and Abelson HI: *Persuasion*, 2nd edition. New York, Springer, 1970.

²Dabbs J and Leventhal H: Effects of varying the recommendations in a fear-arousing communication. *J Person and Soc Psychol* 4:525-531, 1966.

A.K.



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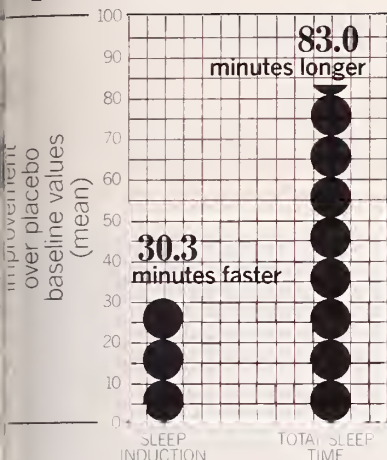
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Results expand and confirm objective proof of efficacy in younger adults with insomnia

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Before prescribing Dalmane (flurazepam HCl), please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and

falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

REFERENCES:

1. Frost JD Jr: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ
2. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ
3. Robinson DS, Amidon EL: Interaction of benzodiazepines with warfarin in man, in *The Benzodiazepines*, edited by Garattini S, Mussini E, Randall LO. New York, Raven Press, 1973, p. 641

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1 Russek HI: AM J M Sc 239:478, 1960



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Shoulder arthrography provides a simple and accurate method to evaluate patients with shoulder disability. No complications occurred in our patients, but iodine sensitivity must be considered a contraindication to the procedure. The procedure is of value in the study of patients with arthritis, rupture of the rotator cuff, adhesive capsulitis, recurrent dislocation of the humerus, and abnormalities of the biceps tendon. Representative illustrations are included.

Positive Contrast Shoulder Arthrography

Edwin S. Wilson, M.D., Mount Holly*

Arthrography of the shoulder joint is a safe and simple radiographic procedure designed to demonstrate the shape and integrity of the glenohumeral joint space. The procedure is virtually without complications, and may be easily performed in any radiographic suite equipped with fluoroscopy and image amplification. Once the technique has been mastered, the procedure may be performed even without benefit of fluoroscopy, should the need arise. Shoulder arthrography provides a graphic demonstration of the anatomic limits of the glenohumeral joint, and is of value to demonstrate any congenital or acquired defects in the integrity of this joint space. The procedure can provide information which may not be available by any other means, short of surgical intervention.

Arthrography of the shoulder was initially performed by Oberholzer in 1933, utilizing air as a contrast medium.¹ Since that time, arthrography has been used by numerous investigators to study patients with arthritis, adhesive capsulitis, recurrent dislocation, rupture of the tendinous rotator cuff, and other causes of shoulder disability.²⁻⁷ The accuracy of shoulder arthrography has been clearly established, and the general acceptance of this procedure in the diagnostic evaluation of patients with shoulder disability has been steadily increasing over the past five years.

Since the signs of shoulder arthrography may be clinically deceptive, shoulder arthrography, utilizing positive contrast medium, provides the means for precise morphologic delineation of the clinical problem in many cases. Orthopedic surgeons vary in their acceptance of this procedure,

an attitude which, in many instances, mirrors the confidence and enthusiasm of their radiologist regarding the examination. Our experience with over 100 arthrograms of the shoulder indicates that the procedure is of definite value in the diagnostic evaluation of patients with acute or chronic disability of the shoulder, especially if the diagnosis is clinically obscure. The procedure causes no serious morbidity to the patient.

Method

The entire procedure is performed in the standard radiographic suite equipped with image intensified fluoroscopy on an outpatient basis. The procedure itself is virtually painless, although there is mild discomfort due to distention of the joint capsule for 24 to 48 hours following the examination.

Materials which are required for the procedure include sterile drapes and towels, a 25 gauge needle for skin infiltration, a 21 gauge needle for subcutaneous infiltration, a 20 gauge spinal needle for arthrocentesis and contrast medium injection, a 10 milliliter syringe for local anesthetic, a 20 milliliter syringe for contrast medium, and 30 centimeter plastic connecting tubing to connect the spinal needle and contrast medium syringe during infusion of contrast medium beneath the fluoroscopic screen. The contrast medium used at our institution is 60 per cent methylglucamine diatrizoate, which produces less reaction than the sodium solution when inadvertently injected into the soft tissues, outside the joint space.

*From the Burlington County Memorial Hospital, Mount Holly, New Jersey, where Dr. Wilson is a member of the Radiology Department.

Prior to the examination, standard radiographs of the shoulder are obtained in the anteroposterior projection during internal and external rotation, as well as bicipital groove and axillary projections. These standard views are examined for correct positioning and technique, as well as for soft tissue calcifications and occult lesions of bone. The anterior approach is most frequently utilized for arthrocentesis, with the patient supine on the radiographic table and the opposite shoulder elevated approximately 35 degrees (Figure 1). This contralateral elevation



Figure 1 — Patient supine on the radiographic table with the contralateral side elevated 35 degrees during arthrocentesis.

from the table surface allows the ipsilateral glenohumeral joint space to be visualized in profile, which will facilitate needle entry into the joint space. The arm is placed in the neutral position, or with slight internal rotation, and an external landmark is located approximately one centimeter below and lateral to the coracoid process of the scapula. The point and its relationship to the glenohumeral joint is confirmed by fluoroscopy, and the point localized by a suitable skin marker. This area is cleansed and prepared using standard surgical aseptic technique, and the skin site is infiltrated with local anesthetic. The spinal needle is then inserted into the subcutaneous tissues, and passed in a direction perpendicular to the table top. Infiltration with anesthetic is continued, and the relationship of the needle to the glenohumeral joint is confirmed when required by fluoroscopy. Mild internal rotation will produce slight compression of the axillary pouch, and a difference in the ease of anesthetic injection will be noted when the

joint space has been entered. Once within the joint space, the plastic tubing is connected to the spinal needle and this tubing is, in turn, connected to the 20 milliliter syringe with contrast medium. The connecting tubing initially should be filled with opaque material to minimize air insufflation into the joint space. With correct needle placement, the contrast medium will flow easily in a thin column over the humeral head adjacent to the glenoid fossa, and into the axillary and subscapular recesses (Figures 2). In-



Figure 2A — Fluoroscopic spot film obtained early during filling of the glenohumeral joint space with contrast medium (arrows).



Figure 2B — Later film from the same examination reveals a thin septum between the axillary and subscapular recesses.

correct needle placement will produce infiltration of contrast medium in an irregular pattern about the needle tip, and will be associated with discomfort if the injection is continued. Once the free flow of contrast medium is visualized under the fluoroscope, the injection is continued until the space is completely filled with contrast medium. This will require 15 to 20 milliliters in the normal patient, and much less in patients

with adhesive capsulitis. The needle is then removed and light pressure placed over the puncture site for a short period. Films are then obtained in the standard projections following mild passive exercise, which is then repeated using active motion. The radiographic series is repeated, with cinefluoroscopy when indicated.

Patients with severe disability and adhesive capsulitis require slight modifications in this technique. Patients with adhesive capsulitis have diminished joint space capacity, which may accept only 5 or 10 milliliters of contrast medium without extravasation about the needle.

Once the films are processed and found satisfactory, the patient is discharged. Generally, mild discomfort will occur for 24 to 48 hours, so patients are instructed to limit activity and use mild analgesics as needed.

Complications

No serious complications have occurred with shoulder arthrography, although mild discomfort after the procedure is fairly common. No significant adverse reaction occurred in our series of patients with shoulder arthrography, although one patient in our larger series of knee arthrography experienced hypotension and generalized urticaria which were controlled by the administration of epinephrine and antihistamine medication. For this reason, we consider iodine sensitivity a contraindication to the examination. Pneumoarthrography may be acceptable as a substitute procedure on these occasions.¹

The Normal Arthrogram

A clear understanding of the normal anatomy is a prerequisite for the recognition of pathologic aberrations of the shoulder arthrogram. The glenohumeral joint is a diarthrodial joint permitting ball and socket rotary movement between the humeral head and the glenoid fossa of the scapula. The humeral head provides insertion for the subscapularis muscle anteriorly, and the supraspinatus, infraspinatus, and teres minor muscles superiorly on the greater tuberosity. These last three provide a common musculotendinous attachment called the rotator cuff, and the long head of the biceps lies within the

bicipital groove between the supraspinatus and subscapularis muscles. While within the bicipital groove, the biceps tendon lies in a separate synovial sheath from which it exists to traverse the joint space and attach along the superior aspect of the glenoid process of the scapula.

The glenohumeral joint space surrounds the head of the humerus, and presents as a thin slit of contrast medium between the humeral head and the glenoid fossa (Figure 2A). There are extensions of this joint space, which form the axillary and subscapular recesses, as well as the synovial sheath about the biceps tendon within the bicipital groove (Figure 2B). The shoulder is covered anteriorly by the subscapularis muscle, which produces internal rotation of the humerus. The subscapular bursa lies between this muscle and the joint space, and there usually is a direct communication between this recess or bursa and the joint itself. There is an axillary recess inferiorly, and this recess may be quite prominent due to laxity of the sling formed by the middle and inferior glenohumeral ligaments. The subacromial bursa lies superiorly, above the rotator cuff, and in the normal patient there is no communication with the glenohumeral joint space.

The normal arthrogram presents a thin slit of contrast medium between the humeral head and the glenoid fossa, which extends over the humeral head to the greater tuberosity (Figure 3A). The contrast medium normally fills the axillary and subscapular recesses, but the subscapular recess is compressed and less well-filled upon external rotation of the humerus, due to compression by the overlying subscapularis muscle (Figure 3B). The biceps tendon is visualized as a negative linear defect within the bicipital groove, and it may at times be recognized traversing the contrast medium-filled joint space. It is also visualized on-end in the bicipital groove projection. On the axillary projection, a thin layer of contrast medium is visualized between the humerus and the scapula, and the synovial sheath about the biceps tendon is visualized anteriorly, along with the subscapular recess (Figure 3C).

The Abnormal Arthrogram

Tear of The Rotator Cuff — Shoulder arthrography is most helpful in the evaluation of



Figure 3A — Normal arthrogram in external rotation reveals contrast medium in a thin layer overlying the lesser tuberosity (white arrow). There is contrast medium within the axillary recess (black arrow).



Figure 4A — External rotation view in patient with rotator cuff tear, with extravasation of contrast medium over the greater tuberosity (white arrow).

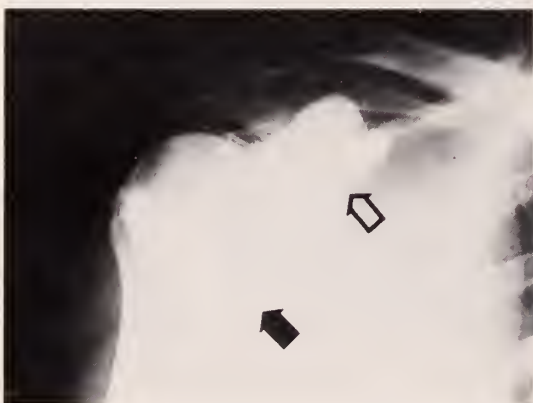


Figure 3B — Internal rotation, with contrast medium in the axillary recess (closed arrow) and subscapular recess (open arrow).



Figure 4B — Internal rotation, with medial displacement of the extravasated contrast medium.



Figure 3C — Axillary view, with contrast extending into the bicipital sheath to outline the biceps tendon (black arrow). A thin layer of contrast medium is visualized within the joint space (open arrows).



Figure 4C — Axillary view reveals contrast medium draped over the head and neck of the humerus.

patients with suspected rupture of the musculo-tendinous rotator cuff. These tears occur most

frequently within the supraspinatus portion of the rotator cuff, just at its attachment to the greater tuberosity of the humerus.² There is normally a thin layer of contrast medium over the humeral head, which terminates sharply at the greater tuberosity. With rupture of the rotator

cuff, contrast medium escapes through the defect into the soft tissues and fills the subacromial bursa (Figures 4A, B, C). Occasionally, the tear is incomplete and the contrast medium fills the supraspinatus tendon like an ulcer crater.⁵ At times the initial films may not demonstrate the rupture, but invariably the films obtained after exercise will demonstrate flow of contrast medium through the rent and filling of the subacromial bursa. Occasionally, the subacromial bursa will be distended by an inflammatory process, and this bursa may be entered instead of the glenohumeral joint space. As Killoran, *et al.* have indicated, the normal joint space must be visualized before the diagnosis of rotator cuff rupture is made.⁵ With tear of the rotator cuff, greater volumes of contrast medium will be required to completely distend the joint space. With complete tear of the rotator cuff, there may be no clear distinction between the normal joint space and the distended subacromial bursa, and contrast medium will spill over the greater tuberosity of the humerus during fluoroscopic filling of the joint space.

Recurrent Anterior Dislocation of the Humerus

— Recurrent anterior dislocation of the humerus produces laxity of the anterior capsule and glenohumeral ligaments, with concomitant enlargement of the axillary recess (Figures 5A and B). This enlargement is best demonstrated with internal rotation of the humerus. Larger quantities of contrast medium may be required to fill this redundant pouch. Arthrography is also of value to exclude associated trauma of the rotator cuff.⁵

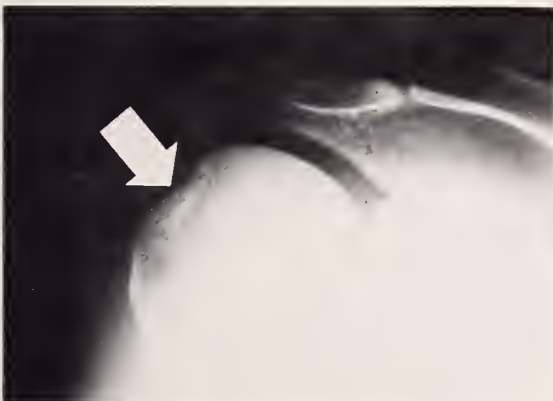


Figure 5A — Plain film of the shoulder in patient with recurrent dislocation reveals the typical Hill-Sachs defect of the posterolateral humeral head (white arrow).



Figure 5B — Arthrogram of same patient with enlargement of the axillary recess, and an irregular defect at the junction with the subscapular recess (arrow).

Adhesive capsulitis — The arthrogram in patients with adhesive capsulitis reveals diminished capacity, with decreased size of the axillary and subscapular recesses (Figure 6). The



Figure 6 — Arthrogram in patient with adhesive capsulitis, with decreased joint space and small axillary and subscapular recesses.

biceps tendon sheath may not fill with contrast medium, but this finding is of uncertain significance in view of the fact that this same structure fails to fill in a significant number of normal studies. The joint space capacity is decreased to five or ten milliliters, and extravasation about the puncture site into the soft tissues is a common finding.

Rupture of the Biceps Tendon — Abnormalities of the synovial sheath and/or biceps tendon may be visualized in patients with rupture of the biceps tendon, and subluxation of the tendon secondary to tear of the transverse bicipital ligament.⁷ Although these lesions are

usually obvious clinically, arthrography is of value to confirm the diagnosis. In patients with tear of the biceps tendon, contrast medium will extravasate beyond the normal synovial sheath and extend down the arm along the long head of the biceps muscle (Figure 7). Subluxation or dis-

don rupture, therefore the finding is not completely diagnostic but suggests the diagnosis when encountered.^{3, 5}

Radiology technicians L. Ellis, B. Repsher, and S. Getz provided technical assistance in preparing this paper.



Figure 7 — Arthrogram in patient with rupture of the biceps tendon, with extravasation of large amounts of contrast medium along the biceps tendon (arrows).

location of the biceps tendon will be recognized on the bicipital groove examination, provided the biceps sheath has opacified during the examination. Extravasation of contrast medium along the biceps tendon has been noted in some patients without the clinical signs of biceps ten-

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“Approximately 95% of the [U.S.] children of ages 1-5 years had iron intakes below the standard”

U.S. Public Health Service (1974)

Where did that surprising statistic originate?

From the first survey designed to assess the nutritional status of the entire U.S. population. The conclusion above was the most striking result reported in the preliminary findings released in January 1974.

Were they really dealing with a true sample of the entire U.S. population?

Those conclusions were based on a sample of 10,126 people—a probability sample established by the U.S. Bureau of Census to reflect the country's total population, regardless of race or income.

Among those 95% with substandard iron intake, how low was their intake actually?

For whites and blacks, for both sexes, for both income levels, the mean intake of iron (as a percent of the standard) for the 1-5 year age group ranged from 60 to 69%. Typically, then, 95 children out of 100 have iron intakes that are only 60% of the standard.

Whose iron intake standard were they using?

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Implication of all this?

That iron deficiency among pre-schoolers is anything but rare and signs like mental apathy, lethargy, irritability, behavior problems, may be telegraphing iron deficiency.

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Is this cited study generally available?

Yes, from the Office of Information, National Center for Health Statistics, 5600 Fishers Lane, Rockville, MD., 20852. Request “First Health and Nutrition Examination Survey”, 1974, DHEW Pub. No. (HRA) 74-1219-1.

*B. Blackwell: The Drug Defaulter. *Clinical Pharmacology and Therapeutics* 13:841 (1972).

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Narrowing down pneumonias

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Bacterial or nonbacterial?

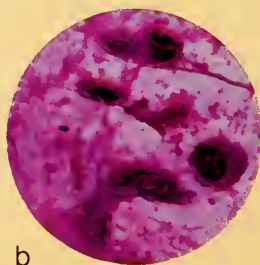
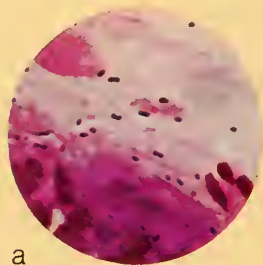
In the early stages of mild to moderate pneumonia, it is often difficult to reach an accurate bacteriologic diagnosis. A tentative differentiation may be made on history-taking, physical examination, CBC with differential analysis, and microscopic study of the sputum smear.

Specimens should be obtained for culture and sensitivity testing, but when a bacterial pneumonia is diagnosed, therapy is often instituted before the etiological agent is positively identified.

Bacterial pneumonias may have a sudden onset with a shaking chill, rapid development of fever, pleuritic pain, and cough productive of rust-colored sputum. The Gram-stained sputum smear generally shows polymorphonuclear neutrophils as well as a predominance of the causative organisms. These are likely to be *Streptococcus pneumoniae*, still by far the most frequently encountered agent in bacterial pneumonia.¹ The CBC reveals marked leukocytosis with a shift to the left.

In **nonbacterial pneumonias**—mycoplasmal or viral—classical symptoms tend to develop more slowly, with myalgia, lassitude, and headache predominating. Sputum production is usually scanty, and the sputum smear is relatively uninformative, showing gram-positive cocci and other organisms which are part of the normal pharyngeal flora. The leukocyte count is normal or slightly elevated.

Direct Gram-stained sputum smears. (a) Pneumococcal pneumonia—note abundant polymorphonuclear leukocytes, as well as gram-positive diplococci. (b) Nonspecific—consistent with viral or mycoplasmal pneumonia. Note large mononuclear cell, as well as a few polymorphs and mixed bacterial flora (pharyngeal contaminants).

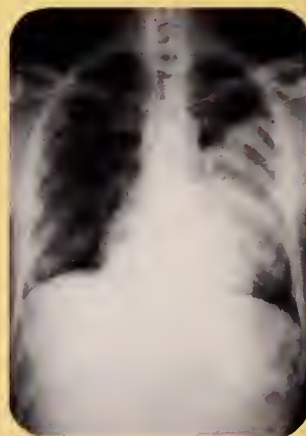


Mycoplasmal or viral?

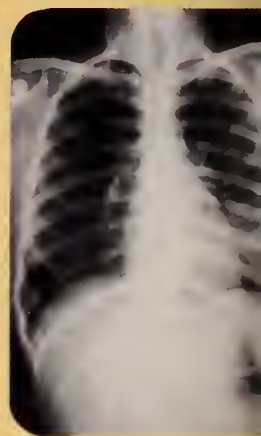
Differentiation between mycoplasmal and viral pneumonias may be impossible in the acute stage.

Serologic testing and culture methods for *Mycoplasma pneumoniae* are complex and time-consuming, taking as long as two weeks after obtaining samples. The sensitivity and specificity of the test for cold agglutinins have been questioned. The complement-fixing antibody test may reflect previous infection. Furthermore, facilities for culturing *M. pneumoniae* are not widely available.³

If treatment is to be initiated, therefore, it may be necessary to start on the basis of a *presumptive* diagnosis of mycoplasmal pneumonia.¹⁻³ In reaching such a diagnosis, the physician relies on clinical judgment, considering such factors as the age of patient and the history of exposure. For example, *Mycoplasma pneumoniae* is considered the most common cause of pneumonia among ambulatory patients aged 20 to 35.¹

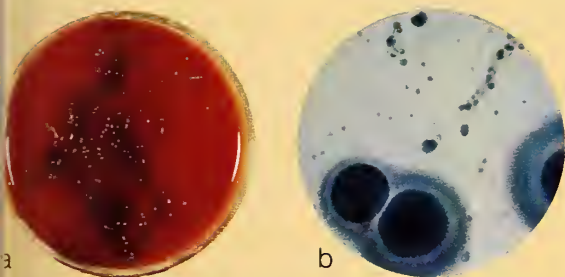


a



b

Chest x-rays of patients with (a) pneumococcal pneumonia—classically heavy, extensive infiltration of left lung; (b) mycoplasmal pneumonia—mild infiltrate confined to left lower lobe. Roentgenography usually does not help in differential diagnosis, since both types of pneumonias may present with a wide spectrum of x-ray as well as clinical findings.



(a) Distinct mucoid colonies of type 3 pneumococci (*Streptococcus pneumoniae*) on sheep blood agar showing greenish discoloration (alpha-hemolysis) of medium. (b) Typical "fried-egg" colonies of *Mycoplasma pneumoniae* consisting of dense central core with lighter periphery. Cultural and serologic methods for detecting *M. pneumoniae* are complex, time-consuming, and not widely available.

Expectant therapy

A patient with a presumptive diagnosis of mycoplasmal pneumonia or bacterial pneumonia, it may be desirable to initiate antibiotic therapy before culture and sensitivity results are available. A course of erythromycin or tetracycline is considered effective in the treatment of mycoplasmal pneumonia to help speed the clearing of infiltrate and shorten the duration of symptoms.^{1,3} In pneumococcal pneumonia, erythromycin is an effective alternative to penicillin, the drug of choice. A recent report, based on data from 200 hospitals of 100 beds or more, found that 95% of *S. pneumoniae* sensitive *in vitro* to erythromycin.⁴

Among these therapeutic agents, only erythromycin provides effective coverage of both *Mycoplasma pneumoniae* and *S. pneumoniae*. The penicillins are not effective against *Mycoplasma*, and *M. pneumoniae* has shown a relatively high incidence of resistance to tetracycline.

When erythromycin is selected for therapy, E-Mycin (erythromycin enteric-coated tablets, Upjohn) is a good choice. E-Mycin is administered and absorbed as active erythromycin base, and may be given q.i.d., q 6h, or b.i.d., immediately after meals or between meals. Thus, patients can use mealtimes to help them remember their medication. The enteric coating on E-Mycin tablets helps ensure efficient absorption in the intestinal tract, and bioavailability studies show that E-Mycin can be expected to produce predictable, acceptable blood levels. The low cost of E-Mycin helps assure economical therapy. E-Mycin rarely causes serious side effects and is not associated with liver toxicity.* The most frequent side effects are upper gastrointestinal, such as abdominal cramping and discomfort, and are dose-related. Nausea, vomiting, and diarrhea occur infrequently with usual oral doses. Serious allergic reactions, including anaphylaxis, have rarely been reported.

Use cautiously in patients with severe liver impairment.

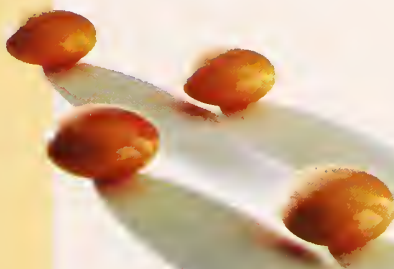
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Summary

Because pneumonias may be difficult to differentiate at the outset, treatment is often initiated before a causal diagnosis is made. However, readily available diagnostic criteria occasionally allow early differentiation between bacterial and nonbacterial pneumonias. When the diagnosis appears to be nonbacterial pneumonia, further differentiation between mycoplasmal pneumonia and viral pneumonia is more complex and time-consuming. Therefore, therapy is often initiated on the basis of a presumptive diagnosis of mycoplasmal pneumonia.

Erythromycin is an effective antibiotic against *Mycoplasma pneumoniae*, *Streptococcus pneumoniae*,† and *Streptococcus pyogenes*.† E-Mycin (erythromycin enteric-coated tablets, Upjohn) is administered and well absorbed as the active base, may be taken immediately after meals or between meals, and is essentially nontoxic.

†Although penicillin remains the drug of choice against these organisms, erythromycin is an effective alternative.



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*Mild to moderately severe, due to susceptible organisms.

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Please turn page for brief summary of prescribing information.

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- For mild to moderately severe infections due to susceptible organisms that commonly invade the respiratory tract
- Essentially nontoxic (see Precautions and Adverse Reactions below)
- Documented bioavailability
- May be taken immediately after meals or between meals
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Alpha-hemolytic streptococci (viridans group): Short-term prophylaxis against bacterial endocarditis prior to dental or other operative procedures in patients with a history of rheumatic fever or congenital heart disease who are hypersensitive to penicillin. (Erythromycin is not suitable prior to genitourinary surgery where the organisms likely to lead to bacteremia are gram-negative bacilli or the enterococcus group of streptococci.)
Staphylococcus aureus: Acute infections of skin and soft tissue of mild to moderate severity. Resistance may develop during treatment.

Diplococcus pneumoniae: Upper respiratory tract infections (eg, otitis media, pharyngitis) and lower respiratory tract infections (eg, pneumonia) of mild to moderate degree.

Mycoplasma pneumoniae (Eaton agent, PPLO): In the treatment of primary atypical pneumonia, when due to this organism.

Treponema pallidum: Infections due to this organism.

Corynebacterium diphtheriae and *Corynebacterium minutissimum*: As an adjunct to antitoxin, to prevent establishment of

carriers, and to eradicate the organism in carriers. In the treatment of erythrasma.

Entamoeba histolytica: In the treatment of intestinal amebiasis only. Extraenteric amebiasis requires treatment with other agents.
Listeria monocytogenes: Infections due to this organism.

Contraindication: Contraindicated in patients with known hypersensitivity to erythromycin.

Warning: Safety for use in pregnancy has not been established.

Precautions: Erythromycin is principally excreted by the kidneys. Caution should be exercised in administering the antibiotic to patients with impaired hepatic function. Surgical procedures should be performed when indicated.

Adverse reactions: The most frequent side effects of erythromycin preparations are gastrointestinal, such as abdominal cramping and discomfort, and are dose-related. Nausea, vomiting, and diarrhea occur infrequently with usual oral doses. During prolonged or repeated therapy, there is a possibility of overgrowth of nonsusceptible bacteria or fungi. If such conditions occur, the drug should be discontinued and appropriate therapy instituted. Mild allergic reactions such as urticaria and other skin rashes have occurred. Serious allergic reactions including anaphylaxis, have been reported.

Treatment of overdose: The drug is virtually nontoxic, though some individuals may exhibit gastric intolerance to even therapeutic amounts. Allergic reactions associated with acute overdose should be handled in the usual manner—that is, by administration of adrenalin, corticosteroids, and antihistamines as indicated and the prompt elimination of unabsorbed drug in addition to all needed supportive measures.

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*Mild to moderately severe, due to susceptible organisms

A confirmed case of tularemia in a 16-year-old male illustrates the classical clinical features of tularemia: history of possible exposure to Francisella tularensis, febrile presentation with a skin lesion, lymph node involvement, and pneumonitis. The patient's convalescence was prolonged with fever, weight loss, and weakness until the laboratory diagnosis prompted appropriate therapy. In view of possible subclinical infection in human beings, serologic tests for tularemia should be evaluated when considering other diseases involving the reticuloendothelial system, especially when a history of exposure to small game animals can be elicited.

Tularemia Presenting as a Lymphoma

Nancy S. Sibert, M.D., Woodbury

This is a report of an infectious illness in a 16-year-old youth where the etiology was not readily recognized or confirmed, thereby causing both the patient and his family mental anguish and suffering.

Case Report

The patient was a 16-year-old male who discovered a "lump" in his left axilla in December, 1974. Medical attention was promptly sought at a local dispensary, where the patient was treated with an oral penicillin preparation. He failed to improve and returned to the clinic where he was told he had "cat scratch fever or rabbit fever," and was discharged. His parents were dissatisfied and sought private medical care; they demanded further diagnostic laboratory evaluation, as they were certain his axillary node was a lymphoma and that he was suffering because of delays in diagnosis.

The patient's history revealed progressive weakness and fatigue, a productive cough which abated after two weeks, intermittent fever, and a fifteen to eighteen-pound weight loss over the previous month. He had always been active and participated in school and extracurricular activities, including hunting and trapping.

Physical findings included fever, a tender left axillary lymph node which measured five centimeters in diameter, and rhonchi in the upper lobe of the right lung; the liver and spleen were not palpable. A white cell count was 10,500 cells with 53% neutrophils and 38% lymphocytes (10% were atypical,) 4% monocytes, and 5% eosinophils. Chest x-ray revealed a consolidated lesion of the posterior segment of the right upper lobe and paratracheal lymphadenopathy. Tine test, heterophile antibody titer and cold agglutinin studies were negative.

Excisional biopsy of the node was performed (as an outpatient) and revealed acutely inflamed, focally necrotizing connective and lymphoid tissue. Routine and fungal cultures were reported as "no growth;" no acid-fast bacilli were visualized.

The patient was then admitted to the hospital for further studies. His physical findings were essentially unchanged, except for the incisional wound of the left axilla. He was quite

apprehensive and depressed. Skin tests for histoplasmosis, coccidioidomycosis, atypical mycobacteria, and tuberculosis were negative. Bronchoscopy revealed no pathology. Mediastinoscopy was performed by a surgical consultant who clinically observed lymphadenopathy which could not be distinguished from lymphoma. The pathologic report of the mediastinoscopy biopsy specimen was lymph node with caseous granuloma. In view of history of exposure to small game animals, bacterial agglutination titers for tularemia were obtained.

Subsequent to his discharge, serologic studies for tularemia by the New Jersey State Laboratory revealed positive titers; the initial titer was 1:640 and one week later the titer was 1:1280.

With the diagnosis of tularemia, the patient and his parents were reassured that no malignant or lymphomatous lesion was present. Intramuscular injections of streptomycin were followed by dramatic resolution of the right upper lobe pneumonitis and by weight gain and general well-being.

Discussion

The clinical spectrum of tularemia caused by *Francisella tularensis* (i.e., *Pasteurella tularensis* and *Bacterium tularense*),¹ usually has been described as quite virulent. Until the description of the epidemic outbreak in Vermont, 1963,^{2,3} it was not readily apparent that asymptomatic or subclinical cases could exist. This was demonstrated by vigorous epidemiologic studies, mainly through use of the tularemia skin test on susceptible populace.⁴ Manifestations of the disease, from subclinical cases to severely ill patients, were found.

Tularemia is an infectious disease whose etiology, clinical presentation and symptoms, and epidemiology were determined through the efforts of Edward Francis and the United States Public Health Service. The causative organism was identified in 1912 by McCoy and Chapin.⁵ It was subsequently named in 1921 by Francis, who determined the organism was responsible

for tularemia, as well as rabbit fever, deer-fly fever, and O'Hara's disease.⁶

The *Francisella tularensis*, which is gram negative, assumes rod and coccoid forms, and is extremely pleomorphic.⁷ It is found in man, rabbits, guinea pigs, rats, mice, squirrels, muskrats, and beavers. It can be transmitted from ingestion of contaminated water or food, animal bites, close contact with the infected dead animal carcass, by such arthropod vectors as mites, mosquitoes, fleas, deerflies, and lice, and by inhalation of infected aerosols by laboratory workers.^{8,9} The diagnosis is usually established by serologic tests. Blood cultures, which are rarely positive, since the organism must be grown on either coagulated egg yolk medium or blood-dextrose-cystine agar, must be obtained quite early in the course of the illness. Early diagnosis can be obtained from culture material obtained from the ulcerated entrance site.

Symptoms usually appear after an incubation period which can vary from two to twenty-five days. Four clinical presentations have been described:

- (1) *ulceroglandular tularemia* characterized by a skin lesion which may be the initial symptom and may not resolve until late in the convalescent stage;
- (2) *typhoidal tularemia* involving necrotizing lesions of the pharynx, gastrointestinal tract and mesenteric lymph nodes;
- (3) *oculoglandular tularemia* which follows invasion of the body through the conjunctiva;
- (4) *pulmonary tularemia*, secondary to hematogenous spread from one of the other forms or primary from inhalation of infected aerosols as seen in laboratory workers.¹⁰

Headache, fever, malaise, and prostration characterize all forms of the disease. Approximately 75 percent of patients will develop a primary ulcerating lesion but rash is rare. Bronchopneumonia occurs in 30 percent of those who acquire the disease. A normal total leukocyte count is common. Recovery is prompt with the appropriate antibiotic therapy, but untreated patients may have a prolonged course with fever, weakness, myalgias, anorexia, and

irritability. Untreated cases have a mortality of 6 to 7 percent; however, mortality is rare in treated cases. The drug of choice is streptomycin but chloramphenicol and tetracycline also ameliorate the disease. Gentamycin has been used successfully.¹¹ Immunity to reinfection is not complete.

Skin tests and bacterial agglutination titers have been reported equally sensitive for detection of tularemia between four weeks and two years from the onset of the disease, however beyond this interval skin tests have proved more effective.¹²

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

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Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it does not enforce the same standards for hundreds of "follow-on" products that it had applied to the original FDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only the cost of the lowest-priced, purportedly equivalent,

generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than \$1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

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The pertinent aspects of embryology, anatomy, and histopathology of lip and tongue cancer are presented with discussion of the differences between these two lesions. The behavior of lip and tongue cancer is delineated and modalities of therapy and reconstruction are presented.

Carcinoma of the Lip and Tongue

A Comparison of Differences*

**Emanuel M. Skolnik, M.D.,
Geoffrey R. Keyes, M.D., and
Michael Friedman, M.D., Chicago**

The variability of behavior of squamous cell carcinoma of the oral cavity is dependent upon numerous interrelated factors with respect to the location of the tumor and the condition of the host. This paper will present a comparison of differences between squamous cell carcinoma of the tongue and lip with attention to their pathological characteristics, clinical presentations, and methods of management. In order to appreciate the various aspects of carcinoma of the lip and tongue, a basic understanding of the embryology, anatomy, and histopathology is mandatory.

Embryology

The embryologic development progresses into the fifth week, mesenchymal proliferation forms a series of elevations around the stomadeum. The frontal prominence maxillary and mandibular swellings occupy positions comparable in spatial relationships to the structures which they will form. Above the stomadeum, on either side of the frontal eminence, emerges the nasal placode. This structure, surrounded by the medial and lateral nasal swellings, develops into the nasal pit. Proliferations of the lateral nasal swelling gives rise to the ala of the nose. Medial nasal swelling growth produces the midportion of the upper lip, maxilla, nose and the entire primary palate.

Concurrently with the development of the lip, two lateral lingual swellings and one medial swelling arise from the proliferations of mesoderm in the ventral aspect of the mandibular arch. The median swelling has been

designated the tuberculum impar. A second medial swelling, designated the copula or hypobranchial eminence, arises from proliferation of the mesoderm of the second through the fourth branchial arch derivative, innervated by the mandibular division of the V cranial nerve. The root of the tongue is likewise formed by the second, third, and fourth arches, thereby receiving innervation from the ninth and tenth cranial nerves via the superior laryngeal. The line of separation of the anterior two-thirds of the tongue from the posterior one-third is called the sulcus terminalis which has as its mid-point the foramen cecum.

Anatomy

In order to gain better understanding of intra-oral cancer and to communicate meaningfully about its clinical characteristics, a nomenclature for staging the disease was developed by the American Joint Committee for Cancer Staging. Tantamount to understanding this staging process is a thorough knowledge of the anatomy. The initial staging of the tumor with respect to its anatomical location, size, and associated nodes is retained regardless of later invasion of other anatomical regions.

The vestibule, bounded externally by the lips and cheeks, internally by the alveolar and dental arches, is the entrance to the alimentary tract. The anterior wall of the vestibule is composed of the superior and inferior lips. The former is limited by the base of the nose superiorly and the nasal labial folds laterally. The junction of the upper and lower lips, the anguli oris, is found opposite the premolar teeth.

*This study is from the Department of Otolaryngology, Abraham Lincoln School of Medicine, University of Illinois, Chicago, and was presented as part of the 3rd Franklin Keim Memorial Seminar, held in Newark, October 2 to 4, 1975.

The tongue is derived from the first four branchial arches thus explaining its rich innervations. Sensory and motor innervations are supplied by cranial nerves V, X and IX, while taste is provided by cranial nerve VII. The root of the tongue is seen at the entrance of the oral cavity where the mobile portion of the tongue joins the floor of the mouth. It is here that the body of the tongue receives its extrinsic musculature. An important anatomical landmark is the *gingivo-lingual sulcus* separating the inferolateral portion of the tongue from the medial aspect of the inferior alveolus. This region is the most frequent site of carcinoma of the tongue. As mentioned, the sulcus terminalis delineates the anterior two-thirds from the posterior one-third of the tongue. The latter is often considered part of the oropharynx.

Histology

Histologic components of the lip include thin keratinizing epidermis replete with hair follicles and in its outer portion, sebaceous glands. More centrally, the orbicularis ori provides its muscular component. The inner surface of the lips is represented by mucous membranes with a minimally defined submucosa. Mixed seromucous, but predominantly mucous glands, lie deep in the submucosa. These glands may not be recognized at the transitional zone of the lip margin.

In contrast to the lip, the tongue is mainly muscular with a mucous membrane envelope. The under surface has a submucosa that is absent on the top surface. Connective tissue projections through the mucosa are termed papilla. There are four types, filiform, fungiform, valvate, and foliate.

Lymphatic Drainage

There is an abundant lymphatic drainage system supplying the lip and tongue. It is through these interwoven lymphatic channels that lip and tongue cancer differentiate themselves via mode of dissemination.

The submental nodes, usually two to three in number, rest in the anatomical triangle formed by the anterior bellies of the digastric muscles and the hyoid bone. Anterior to the subman-

dibular gland, the preglandular, prevascular, and retrovascular nodes can be found just inferior to the mandible. Other critical nodes include the so-called first echelon nodes of the jugular chain. The jugular digastric or subdigastric nodes can be found near the posterior belly of the digastric muscle at the entrance of the common facial vein into the jugular chain.

The vestibule is drained primarily through mucocutaneous channels into the submental and submandibular nodes. Classically, the prevascular node of the submandibular group is of primary importance. When dealing with cancer of the upper lip subparotid and preauricular nodes also assume clinical importance.

The lymphatic drainage of the tongue is no less organized. Drainage from the mucosal and muscular plexi travel into the anterior, marginal, central, and posterior trunks lying on the inferolateral region of the tongue. These trunks continue into the submandibular, subdigastric, and bifurcation nodes in an overlapping pattern terminating in the jugulodigastric and jugulohyoid nodes. Carcinoma of the base of the tongue is often first detected as a result of the emergence of a large jugulodigastric node causing the patient to seek medical attention.

Pathology

Squamous cell carcinoma predominates as the histopathologic type of carcinoma of the lip. Eighty-five percent are classified as grade I and grade II. Adenocarcinoma may arise in the minor salivary glands of the lip and occasionally melanocarcinoma and fibrocarcinoma are reported. The upper lip carcinomas are usually of the basal cell variety because they mainly arise in the skin instead of the mucous membrane.

The lower lip lesions usually arise in an area of superficial ulceration, leukoplakia or hyperkeratosis. These lesions are classified according to their gross and histologic appearance into verrucous, ulcerative, and exophytic.

The histopathology of tongue cancer likewise is of the squamous cell variety in most cases. Adenocarcinoma of the salivary glands has been

documented as has a rare case of cancer of aberrant thyroid tissue at the base of the tongue. There have also been reported lymphosarcomas arising in the lymphoid tissue at the base of the tongue.

Incidence

The incidence of carcinoma of the lower lip is about twenty times greater than that of the upper lip and about twenty times more frequent in men than in women.¹ Etiologic considerations are pipe smoking, atmospheric irritation secondary to the sun, dust, and dryness. The disease is much more common in Caucasians than in Negroes. Usually found in the fifth decade of life, these tumors, however, have been reported in the third decade. Carcinoma of the lip has the lowest mortality of all head and neck cancers owing, in part, to its tendency not to metastasize early.

In contrast to cancer of the lip, cancer of the tongue is often first diagnosed by a mass in the neck, usually secondary to a posterior third of the tongue lesion. Instead of the cosmetically bothersome lesion, tongue cancer often persists asymptotically until local pain, dysphagia, or referred pain to the ear prompts the patient to consult a physician.

The large majority of these lesions occur in the fifth to eighth decade in people who smoke and drink heavily. The incidence is far greater in men than women but lesions in women seem to be increasing. Carcinoma of the tongue remains one of the most rewarding lesions with respect to therapeutic management.

These cancers are classified as anterior tongue or posterior tongue lesions dependent on their position anterior or posterior to the circumvallate papilla.

Management of Lip Lesions

The management of cancer of the lip and tongue must be undertaken with a thorough knowledge of the pathologic process, overall condition of the patient and current modalities of therapy. Careful analysis of these factors should lead to a systematic disciplined approach to the patient's disease.

Initial workup should proceed with careful observation of the cardiorespiratory, endocrine, hepatorenal, and hematopoietic system. The patient's psychological status and habits with respect to tobacco and alcohol must also be considered in the decision of management.

Examination and assessment of the tumor should be recorded using the American Joint Committee TWM classification. As described previously, characteristic differences in lymphatic drainage, aggressiveness of the tumor itself, and time of diagnosis differentiate the two lesions at their outset. The five-year survival rates should approach 95 percent for carcinoma of the lip and 50 percent for carcinoma of the tongue. If cervical node involvement ensues with a lip lesion, survival rate drops abruptly to within the range of tongue cancer figures. For these reasons, therapy must be geared to the individual and his lesion. The major modalities of therapy at present include radiation therapy, chemosurgery, chemotherapy, and surgery. These disciplines are employed separately or conjointly depending on stage of disease.

Radiation therapy may be used as a primary modality and as a pre- or postoperative adjunct. Current thinking with respect to epidermoid carcinoma of the lip is toward surgery. Although it has been stated that either surgery or radiation therapy will cure squamous cell carcinoma of the lip in about 95 percent of cases, there are a number of disadvantages with the use of radiation.

Initially, the cosmetic appearance with radiation is more pleasing but after a few years, when scarring has taken place, the results are less than satisfactory. In addition, the possibility of soft tissue or bony radionecrosis are additional deterrents to the use of radiation therapy. As previously stated, therapy must be geared to the individual. For the elderly patient who may not be able to withstand general anesthesia, radiation therapy probably should be the procedure of choice. Radiation may be delivered by the external approach using superficial and orthovoltage or by interstitial or radium therapy, depending upon whether the lesion is exophytic, ulcerative, or verrucous.

Management of Tongue Lesion

Treatment of carcinoma of the tongue must be dependent upon the size and location of the lesion, the presence or absence of clinically palpable cervical nodes, and the general physiologic status of the patient.

Until recently, low voltage radiation alone or in conjunction with surgery prevailed. Most carcinomas of the tongue are radiosensitive, with the exception of adenocarcinoma and cylindroma. Lymphosarcomas are especially sensitive to radiation, which is their primary management. However, low salvage rates (less than 25 percent based on determinate cases), although comparable to temporary results, are considered unsatisfactory.

Our approach to carcinoma of the tongue is surgical with primary reconstruction when possible. Lesions of the anterior portion or lateral margin of the tongue are excised, if less than two cm, with primary closure. The cure rate approaches 70 to 80 percent for these lesions because of the low incidence of nodal metastasis. Radiotherapy may provide similar cure rates but must be given over a longer period of time.

For lesions greater than two cm and located in the anterior or lateral regions of the tongue, a composite procedure is executed. Discontinuous procedures are ill advised and violate basic surgical principles. The question of elective versus therapeutic neck dissection remains the subject of debate. The concept of elective neck dissection has been reported previously.⁸ Som has stated that any attempt to estimate the value of the elective neck dissection in carcinoma of the mouth must be based on the assumption that every untreated occult cervical node will ultimately lead to disseminated metastasis and the demise of the patient.⁹

The dosage of preoperative radiation therapy (2000 versus 5000 rads) has not been shown to alter significantly the course of tongue cancer. There may be something to be said about an optimal preoperative radiation dosage followed by an appropriately timed surgical attack.¹⁰ Nonetheless, we employ postoperative radiation therapy as our main attack on large tongue lesions with nodal metastasis.

Therapy for cancer of the base of the tongue (pharyngeal) is less effective because of the anaplastic nature of the tumor, the frequent bilateral infiltration, and the high incidence of metastasis, which is often bilateral. Because of the low survival rate (10 to 15 percent) and high morbidity associated previously with surgery, radiation has been favored. However, metastasis is not controlled and the results are disappointing, including a high incidence of recrudescence at the primary site. Surgery again assumes the dominant role and these lesions may require composite resection with homolateral or bilateral neck dissection.¹¹ This is best applied to small lesions of the base of the tongue in a unilateral location but, when the midline is approached, approximately three-quarters of the tongue must be removed. If more of the tongue is involved, total glossectomy, laryngectomy, and bilateral neck dissection must be performed. In younger individuals, the larynx may be preserved. However, rehabilitation is most difficult since deglutition and respiration are compromised. If problems with alimentation are anticipated, a temporary feeding pharyngoesophagostomy is a comfortable and useful way to avoid the untoward sequelae attending the prolonged use of the indwelling nasogastric feeding tube.¹²

Reconstruction of tissue voids may be accomplished with split thickness skin grafts or flaps depending on the size of the deficit. The delto-pectoral flap, forehead flap, or local neck flaps, may be used to resurface large tissue voids. Flaps may need to be lined necessitating delayed closure of wounds in certain instances. The decision of how and when to reconstruct is dependent upon the goals hoped to be achieved by the surgery. If treatment has been palliative for conversion of a patient from institutionalized care to outpatient care, reconstruction would probably not be justifiable.

The following are the basic methods for closure of defects: immediate closure by the use of adjacent tissue, skin, or mucous membrane flaps, or incorporation of skin and mucosa as a full thickness cheek flap; split thickness skin grafts for primary surfacing; lined pedicle flaps from the forehead, neck, or chest to close fistulas primarily; and delayed closure by the use of a

pedicle flap lined by split skin graft, particularly in heavily radiated areas.

Adjacent or regional flaps are preferred to distant flaps, and tubed pedicles are not so desirable. Such flaps have the advantage of color matches, appropriate texture and hair covering abundant surface area, excellent vascularity, and minimal loss by contracture and resorption. Composite grafts with bone or ribs are not successful either functionally or cosmetically.

Reconstruction of mandibular defects in the composite resection is usually unnecessary. Relatively good positioning of the mandibular segment can be accomplished with a pin, but this is inadvisable in patients who have received extensive radiation (4000 to 6500 rads) to the tumor site. However, the operation does have the advantage of stabilizing the mandible and offers better occlusion for fibrosis and relative fixation.

Management (Tongue)

Should reconstruction be warranted, immediate non-delayed techniques are preferable to minimize postoperative disability and the extent of the deformity.

To resurface the oral cavity, adjacent buccal mucosa may be advanced or transposed. For selected instances, palatal or lingual mucosa may be utilized to provide covering. The split-thickness skin graft may be used to surface comparatively large areas. Dermal or full-thickness skin grafts are mainly dependent for their nutrition upon the ingrowths of blood vessels from the margin of the defect. Consequently, nutritional requirements in these grafts are such

that distances greater than one cm from the margin must not be exceeded. The same vascular needs are essential for the survival of composite grafts.

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Inflammatory disease of the salivary glands can usually be diagnosed on the basis of history, physical examination and x-ray findings. An accurate assessment of neoplastic disease can often be made, but definitive diagnosis almost always requires excisional biopsy. This involves excision of the entire submandibular gland or subtotal or total parotidectomy. Malignant tumors of the salivary glands often require radical resection of adjacent structures. When the facial nerve is injured, it should be repaired or grafted whenever feasible.

Surgery of Major Salivary Glands*

Emanuel M. Skolnik, M.D., Michael Friedman, M.D., and Geoffrey R. Keyes, M.D., Chicago

Although relatively infrequent, salivary gland tumors have been the subject of many reports. This is partially due to the multitude of confusing statistics and data available, the confusion with regard to classification and the difficulty in comparing the different salivary glands with respect to incidence of tumor involvement. In addition, all reports on treatment have been retrospective studies of uncontrolled series which are necessitated by the small number of cases with the large variety of pathology. The purpose of this paper is to review the literature on salivary gland tumors and to review the case material from our institution in order to provide an overall picture of the salivary gland tumors and salivary gland disease with respect to diagnosis and management. The paper will concern itself mainly with diseases of the major salivary glands.

Currently the most widely accepted classification of salivary gland tumors is that based on the work of Foote and Frazell.¹ This classification is reviewed in Table 1. Their classification is based not only on the peculiar histologic appearance of the tumor but also on a study of the correlation between histologic and clinical features of the different salivary gland tumors.

The relative incidence of salivary gland tumors is in the range of three to twelve percent of all head and neck tumors.^{2,3} The distribution of these tumors, based on location and type of pathology, is shown in Table 2. Based on all the studies, the most commonly involved gland is

the parotid and the most common tumor is the mixed tumor. Approximately 10 percent of cases involved the submandibular gland; half of these are benign and half are malignant. Sublingual tumors are very rare and usually malignant.

Table 1

Type	
Benign	Pleomorphic adenoma
	Papillary cystadenolymphoma
	Oncocytoma
	Miscellaneous benign (basal cell adenoma, glycogen rich adenoma, sebaceous lymphadenoma)
Malignant	Carcinoma expleomorphic
	Mucoepidermoid carcinoma
	Adenoid cystic carcinoma
	Acinous cell carcinoma
	Adenocarcinoma
	Undifferentiated carcinoma
	Squamous cell carcinoma
	Miscellaneous (sebaceous, oncocytic and Stensen's duct)

Applied Anatomy

Parotid, Submandibular and Sublingual Glands
— The parotid gland insinuates itself in and around certain muscles, nerves, fascia and bones. Parotid malignancy has little respect for these adjacent tissue barriers. Although the concept of a bilobed gland has been useful in conservation of the facial nerve in parotid surgery, the parotid gland is in reality single-lobed both embryologically and grossly. Gasser, who recently confirmed the unitarian nature of the gland, demonstrated the encircling of the facial nerve by a developing ingrowth of parotid primordium.⁴

*This study is from the Department of Otolaryngology, Abraham Lincoln School of Medicine, University of Illinois, Chicago, and was presented as part of the 3rd Franklin Keim Memorial Seminar, held in Newark, October 2 to 4, 1975.

Table 2
Head and Neck Neoplasm
(Salivary Gland Averages)

75-85%		10%			9%		1%	
Parotid		Submax.			Minor		Sublingual	
Ben. 80%	Mal. 20%	Ben. 50%	Mal. 50%		Ben. 25%	Mal. 75%	Ben. 10%	Mal. 90%
Diagnosis								
	<i>Duration</i>	<i>Pain</i>	<i>Nerve</i>	<i>Mobil- ity</i>	<i>Consistency</i>	<i>Sialo- gram</i>	<i>Needle Aspira- tion</i>	<i>Other</i>
Inflammatory disease	sudden, recurrent occ. per- sists for years	present	not involved	normal	diffused enlarged	very helpful	not indicated	medical treatment usually adequate
Mixed tumor	years	none	not involved	normal	discrete firm mass	not helpful	usually not diagnostic	
Cysts	years	none	not involved	normal	cystic	not helpful	usually diagnostic	
Warthin's tumor	years	none	not involved	normal	firm	not helpful	usually not diagnostic	may be bi- lateral
Lympho- epithe- lial Disease	years	occa- sional	not involved	normal	may be diffuse involvement or discrete soft or firm mass	very helpful	not diagnostic	systemic work-up includes sed. rate, ANA, rheumatoid factor indicate
Malignant disease	months occ. change in size in long- standing mass	frequent	20-30%	fixed	stony hard	not helpful	may be diagnostic	

The parotid gland is associated with a superficial or paraglandular chain and a deep or intra-glandular chain of lymph nodes. The superficial nodes drain anterior auricle, temporal and upper facial regions and then empty into the superficial nodal chain along the external jugular vein. The deep chain drains the glandular substance and then empties into subparotid nodes. Both chains eventually drain into the jugulodigastric chain.

Since the fascia around the submandibular gland is very loosely attached to the capsule, in contrast to the parotid gland where it is fused, the technique of shelling out the gland has been used in tumor surgery. This capsule, however, is by no means a barrier to malignant disease which has

often spread beyond the capsule microscopically even without any clinical evidence of spread. The lymphatic drainage of the submandibular gland is again divided into two chains: the surface and lateral aspects of the gland drain into the submandibular nodes, while the deep portion of the gland drains into the jugulodigastric and deep cervical nodes.

Lymphatic drainage of the sublingual gland is very similar to that of the submandibular. The anterior portion of the gland drains into the submaxillary lymph node and the posterior two-thirds to three-quarters drains into either the jugulodigastric or mid-cervical nodes (between post belly of the digastric and anterior belly of the omohyoid).

Diagnosis

All discrete masses in the parotid or submandibular gland should arouse suspicion of malignancy. The surprisingly caudal extent of the tail of the parotid may lead to initial tumor discovery in the cervical region. Tumors in the deep portions of the parotid gland may present as retromandibular or pharyngeal submucosal masses which are entirely intraoral. Hard fixed masses without surrounding inflammation, suggest malignancy. Partial or complete facial nerve paralysis ordinarily indicates malignant invasion of the nerve, although reports of facial paralysis associated with benign swelling are increasing. Other rare findings that are indicative of malignancy are pain or anesthesia in the face, tongue or ear via involvement of the greater auricular, auricular temporal or lingual nerve. The submandibular malignancies will usually remain painless unless there is extension to the floor of the mouth or mandible. Soft tissue x-ray may be helpful, but is ordinarily nondiagnostic. Occasionally, sialolithiasis and mandibular tumors may initially masquerade as salivary gland malignancy and sialography and xerosialography are helpful in differentiating these chronic inflammatory states from malignancy.

Excisional biopsy analysis provides the most reliable index of malignancy in the parotid gland. These are ideally obtained with parotid tumors by superficial lobectomy of the gland to provide a generous margin around the lesion. Although this point has been stressed in previous publications, many patients are referred after incomplete procedures of shelling out the tumor. Deep lobe excision is required if the tumor arises there and the superficial lobe is usually excised as well. The ultimate extent of surgery must depend upon frozen sections and histopathological interpretation. Frequently, cryostat sections may be inconclusive so definitive surgery should await confirmation. This is especially true with malignant mixed tumors which are often misdiagnosed with the error toward the malignant side. Eighty-one percent of the cases reviewed by Gerugthy, *et al.*, that were originally diagnosed as malignant mixed tumors eventually represented other forms of salivary gland tumors.⁵

Incisional needle biopsy has a very limited usefulness in proper diagnosis of salivary gland tumors. Byers found that the correct diagnosis was established in only one out of eight patients in whom needle biopsy was performed. The other seven biopsies revealed insufficient tissue in three, incorrect diagnosis of benign disease in two and malignant diagnosis of incorrect cell type in two.⁶ Zayicek and Everett, on the other hand, have found that aspiration biopsy has a high degree of accuracy after studying 100 consecutive cases of carcinoma.⁷ We have never found incisional biopsy to be very useful and rarely utilize this technique for diagnosis with salivary gland tumors.

Associated Disease

In 1968 Berg, *et al.*, reported on the follow up of 396 patients with carcinoma of a major salivary gland and found that the subsequent incidence of breast cancer was eight times the expected figure.⁸ Salivary gland tumors were also found to be increased more than five-fold among survivors of the atomic bomb in Japan.⁹

Inflammatory Disease

The most common etiology of acute sialadenitis in the submandibular gland is obstruction due to a calculus. The acute inflammatory condition usually can be controlled with antibiotics. Calculi are much more rare in the parotid gland, but a frequent precipitating factor of acute inflammation is dehydration. The gland is usually swollen, painful, and tender; purulent exudate can be expressed from Stensen's duct. Treatment is medical with adequate hydration and antibiotic therapy based on cultures of duct exudate. If infection persists, multiple lobular abscesses may occur and must be treated surgically by exposure of the entire gland and by carefully opening the fluctuant areas by spreading the hemostat in the direction of the facial nerve.

Chronic, recurrent sialadenitis can be seen in both parotid and submandibular glands, usually as a result of calculi or ductal or stomal stricture. A sialogram is often helpful in the diagnosis. Surgical excision of the submandibular gland is simple and curative in these cases. When the parotid is involved, repeated in-

fections often create scarring around the facial nerve which makes superficial parotidectomy with preservation of the nerve a difficult and tedious procedure.

Chronic progressive inflammatory diseases are usually caused by actinomycosis or tuberculosis. Bacteriological diagnosis can be made by identification of these organisms, but this is often difficult. The pathologist must be informed of these possibilities so special stains of specimens can be made. Treatment involves both surgery and appropriate antibiotics.

Benign Lymphoepithelial Lesions

Benign lymphoepithelial lesions include what was formerly called Mikulicz's disease, Sjogren's Syndrome, solid adenolymphoma, lymphomatoid adenoma, chronic inflammation, chronic lymphoepithelial sialadenopathy, chronic punctate parotitis and lymphoepithelioma of the salivary glands. Goodwin¹⁰ initiated the uses of the term benign lymphoepithelial lesions to replace all the previously used terms with respect to parotid gland. Kelly showed the same process to be present in other salivary glands.¹¹ The histopathology of these diseases includes lymphoid proliferation, intraductal proliferation, epimyoeplithelial islands, and acinar atrophy.

Clinically, this is seen most often in middle-aged and older female patients with recurrent, occasionally painful swelling in one or more salivary glands, usually the parotid. The process sometimes is aggravated by superimposed bacterial infection. On examination, the findings vary from a small discrete mass within the gland to enlargement of the entire gland. The mass is usually soft, mobile, and not tender. Needle aspiration is usually not valuable in diagnosis.

These lesions may be isolated to one involved gland or may be part of a syndrome involving all salivary and lacrimal glands presenting with xerostoma and xerophthalmia. Many cases may also be part of or a predecessor to Sjogren's syndrome with rheumatoid arthritis.

Sialography shows terminal or punctate sialectasis. In reality these findings have been shown

to be due to extravasation of contrast material through the weakened duct wall in a punctate fashion. Although formerly considered to be pathognomonic, similar changes also have been described in carcinoma of parotid. Laboratory studies should include antinuclear antibody (ANA) rheumatoid factor, direct Coombs test, precipitating antibodies, antithyroglobulin antibodies and macroglobulins. These tests may suggest systemic involvement with a collagen disorder.

If the mass is firm and localized, subtotal parotidectomy is indicated to establish a diagnosis and rule out malignancy. Asymptomatic diffuse masses with classic sialography findings can be observed; if they progressively enlarge, open biopsy should be performed. If patients are symptomatic or have recurrent bouts of bacterial infection, total parotidectomy with preservation of facial nerve is indicated.

Cysts

Cysts of the salivary glands are rare, occurring in three percent of cases. Cysts of congenital origin may be either ductal ectasias or associated first or second branchial pouches; dermoid cysts may occur within the parotid fascia. Sialadenitis and sialolithiasis may cause obstructive cysts. Clinically, it is difficult to differentiate a cyst from other benign tumors so the diagnosis is usually made by excision. Aspiration in these instances may be diagnostic and should be performed if a cyst is strongly suspected.

Mixed Tumors (Pleomorphic Adenoma)

Excision of the superficial lobe of the parotid with dissection and preservation of the facial nerve was, and remains, the recommended procedure for mixed tumors of the parotid. Four patients who had excision of the mass alone, performed elsewhere, were seen for recurrence. These patients were treated by superficial parotidectomy with no further evidence of recurrence in three patients. The fourth patient was treated with superficial parotidectomy after recurrence and showed evidence of disease one year after surgery. In 12 percent of the patients,

total parotidectomy was necessary. Complete seventh cranial nerve paralysis occurred in only one patient, while transient paresis with complete recovery occurred in four cases. The low incidence of recurrence and complications certainly justifies a complete superficial parotidectomy as the treatment of choice when compared with the high incidence of recurrence (30 to 40 percent) reported when inadequate excision was the common procedure.¹² Mixed tumors of the submandibular gland were treated by complete excision of the gland with no recurrence or complications.

Recurrent mixed tumors are more difficult to deal with surgically. The basic operation should be total parotidectomy with preservation of the facial nerve. Although mixed tumors have been shown to be unicentric in origin, their recurrences are often multicentric which makes preservation of the facial nerve very difficult and, at times, impossible. This difficult dissection is approached best with the aid of the operating microscope. Secondary branches of the nerves may have to be sacrificed, but immediate facial nerve graft is recommended if the main trunk is severed.

Malignant mixed tumors are rare, comprising three percent of our cases. In other large series, they comprise two to nine percent of the entire mixed tumor category.¹³⁻¹⁵ Eneroff and Zetterberg studied the relationship between the preoperative duration of the tumor and incidence of malignancy in mixed tumors. They found that the incidence of malignancy was 1.6 percent of 430 cases present less than four years, whereas the incidence of malignancy in 48 tumors present for more than 15 years was 9.4 percent. In a small group of patients with tumors present for more than 30 years, the incidence of malignancy was greater than 20 percent. Eneroff, *et al.*, further showed that the DNA characteristics, studies by microspectrophotometry in pleomorphic adenoma with prolonged clinical course, is similar to the characteristics of malignant disease and different from the DNA of pleomorphic adenoma of short clinical courses.¹⁶

These studies clearly demonstrate the need for early operation on all parotid tumors. The

theory that a tumor which has been present for many years is probably benign and should be left alone is to be condemned.

Warthin's Tumor

The second most commonly encountered tumor is Warthin's tumor (papillary cystadenoma lymphomatosus). Although this tumor has been reported in patients of any age (2.5 to 92 years), 82 percent are found in patients between 41 and 70 years of age (average 55.6 years). There is a five to one male predominance. In our patients, Warthin's tumor comprised 13 percent of all parotid tumors, while other authors report an incidence of six to ten percent.^{17,18} It occurs most often in the lower pole of the gland next to the angle of the mandible. There have been several reports of bilateral Warthin's tumors and in one of our cases, Warthin's tumor was found in a gland removed for another tumor.

Diagnosis may be aided with the use of Technetium 99m scan, in which Warthin's tumor will show up as a hot nodule. Treatment is superficial parotidectomy; in our series, no recurrences were noted.

Mucoepidermoid Carcinoma

As the name implies, the two main histologic features of this tumor are epidermoid and mucus-secreting cell patterns. They comprise 23 percent of parotid malignancies. These tumors may be solid, cystic, or semicystic and are generally divided into three degrees of malignancy; high, intermediate, low. The high grade malignant tumors in our series were all hard. These tumors are generally considered not to be radiosensitive therefore the primary treatment approach is surgical. For low-grade malignancies that approximate the facial nerve, total parotidectomy with nerve excision and immediate nerve graft is recommended. If adequate margins can be obtained with conservation of the nerve, partial resection may be adequate. Radical neck dissection or postoperative radiation is not recommended without the presence of metastasis. Treatment for high-grade malignant tumors is minimally a radical parotidectomy. Aggressive local extension may necessitate radical resection including temporal bone, mandible and skin. Immediate nerve graft is not

recommended and most cases should be given a full course of irradiation. Histologically positive nodes, without clinical evidence of neck metastasis, were rare so radical neck dissection is not performed unless there is clinical evidence of metastasis.

Adenoid Cystic Carcinoma (Cylindroma)

Four percent of our parotid malignancies were classified as adenoid cystic carcinoma. Although the most common type of malignancy seen with minor salivary gland, it is not as prevalent as parotid tumors. Although metastasis is not usual at initial presentation, late metastasis alone or associated with recurrent local disease is very common. Very small tumors may be treated with preservation of the nerve. Larger tumors are treated with total parotidectomy and immediate nerve graft. Closer observation for extended periods of time is required and metastasis or recurrence can be treated with further surgery, if feasible, or with radiation.

Squamous Cell Carcinoma

Our series showed higher incidence of squamous cell carcinoma than most reported series. Sixteen percent of the malignant tumors were classified in this category. They frequently showed aggressive local invasion with neck metastasis. Treatment is radical parotidectomy, radical neck dissection and radical resection of adjacent structures if necessary. All of our patients had postoperative radiation. Prognosis is poor especially when advanced disease requires radical surgery.

Adenocarcinoma

All tumors which could not be specifically classified as acinus cell, mucoepidermoid, or adenoid cystic types were placed in the broad category of adenocarcinoma. These tumors behave in a very aggressive fashion both locally and with frequent metastasis. Thirty-five percent of parotid tumors in our series were classified as adenocarcinoma. Treatment was radical parotidectomy in most cases often with radical resection of temporal bone and mandible. Radical neck dissection was not routinely performed but is advisable with large tumors. Local metastasis occurs in approximately 25 percent of

cases and distant metastasis is not uncommon.

Malignant Disease — Submandibular Gland

Malignant disease of the submandibular gland represents 40 percent of the submandibular tumors in our study. Other series report similar incidence.^{6,19-21} The most common malignancy in our studies as well as most other series is adenoid cystic carcinoma.^{6,19-21} Our policy for treatment has been to be prepared for radical surgery. If the tumor extends to the mandible or floor of the mouth, en bloc radical resection is performed. If no clinical extension is found, the gland is excised and a frozen section obtained to determine any evidence of nerve, periglandular soft tissue or local node involvement. If these are found to be positive, radical resection is carried out. Byers, *et al.*, studied 36 patients with malignancy of the submandibular gland and found that nerve invasion was associated with a higher incidence of subsequent nodal involvement. As with parotid malignancy, all cases of squamous cell carcinoma and all cases with questionable margins are followed with postoperative irradiation.

Facial Nerve Repair and Grafting

Direct nerve repair is rarely applicable in radical ablations of the parotid gland, but may be considered with certain benign lesions and in the treatment of inadvertent lacerations of the facial nerve. The best time to resuture a nerve is at the time of injury, so any laceration should be repaired immediately. Any patient with facial paralysis in the immediate postoperative period should be re-explored unless the course of the nerve was identified as being intact at the time of closure. Secondary repairs are complicated by scarring and neuroma formation. The importance of aligning the nerve segments without distortion cannot be overemphasized.

In radical surgery with resection of temporal bone and facial musculature, nerve repair is unrealistic. However, after parotid resection for some benign tumors and many malignant tumors, facial function can be restored by nerve grafting. Many nerves have been used, but we have found the cervical plexus to be ideal. If the

tumor extends to the neck, the contralateral side is used. A single nerve or a main trunk with several terminal branches is matched to the defect in the facial nerve. The anastomosis requires the same technique for nerve repair and nerve grafting and is best accomplished with the aid of the operating microscope. Size 8-0 monofilament nylon is used to suture epineurium to epineurium in four quadrants for the main trunk. This technique can be used for most large branches with the microscope. However, if small branches are anastomosed one carefully placed suture through the body of the nerve, as described by Conley, is adequate.²¹ The anastomosed site is protected with a small piece of silicone tubing.

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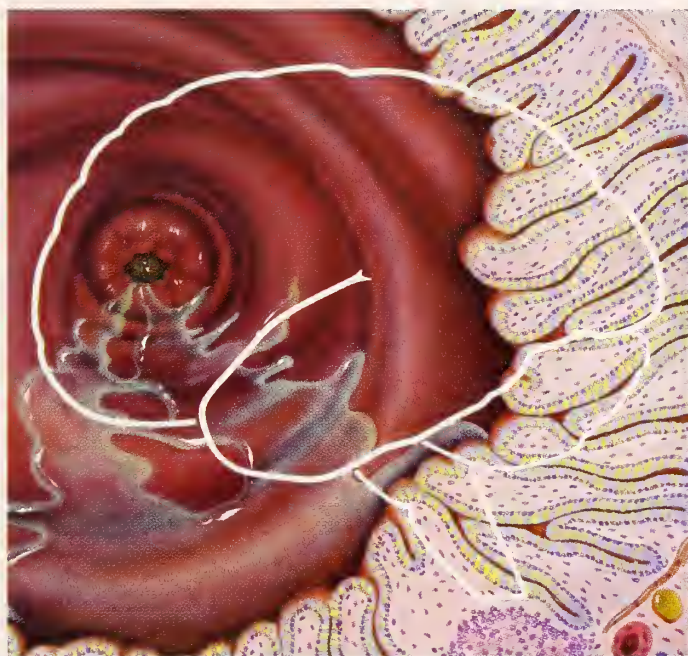


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Arteriography, brain scanning, and computerized axial tomography are making surgical lesions readily diagnosable. However, the primary diagnostic effort depends on the family practitioner, the psychiatrist, and the neurologist to aid in ferreting out the early symptoms of brain tumor. A knowledge of abnormal psychological function is essential. In some instances these abnormal functions may demand neurosurgical consultation or neuroradiologic aids or both. A plea is made for neurologists, neurosurgeons, and psychiatrists to break down classical specialty boundaries and work for the benefit of the mentally-ill patient.

The Psychiatric Symptoms of Patients Having Neurosurgical Lesions

Robert G. Fisher, M.D., Plainfield*

The recognition of neurosurgical disease problems that may be encountered in a psychiatric service may be most difficult at times. Errors are certain to be made. In analyzing the errors in diagnoses of 115 cases of brain tumor Purves-Stewart¹¹ concluded that the problem was one of insufficient observation or the tendency to cling to the first conception of the case. Those of us who have dealt with numbers of patients over the years are keenly aware of the difficulty of the early diagnosis of brain tumors, which demands a careful analysis of the history and physical examination as well as the advantages of laboratory and radiologic studies.

Brain tumors, subdural hematoma, and low pressure hydrocephalus are clinical problems in patients at mental institutions which frequently escape early detection by the usual means.

The following neurosurgical problems serve as illustrations.

Case Reports:

Case 1: A fifty-five year-old dance hall operator had worked hard all of his life until approximately one year before admission to the hospital. At that time, he had made purchases beyond his usual means for "furnishings for the dance hall." He had no headaches nor seizures, but he was noted to be more jovial and "frisky" than his wife could tolerate. He drove a car, ate well, and worked daily until three weeks before admission to a mental institution. He was then noted to be making serious errors in counting out change to his customers and was progressively confused.

On admission his physical examination disclosed no sensory, motor or deep tendon reflex change, but there was a peculiar "witselsucht" or "slap-happiness" and he was found to be in-

continent. An electroencephalogram disclosed an abnormality which was suspicious for a lesion of the right frontal lobe. The patient was sent for a neurological examination and then transferred to a neurosurgical facility.

On examination, he was slightly disoriented and laughed inappropriately at most comments and questions. He drifted in his conversation, was repetitive in his speech and the 100-7 series was poorly done. His memory for childhood and early years was intact, but he forgot the phone number of his dance hall and forgot the route that he had taken from the mental institution to the general hospital. His neurological examination was negative; there was no papilledema.

X-rays of the skull and chest were negative. The brain scan and arteriogram disclosed a right frontal lobe tumor. A benign astrocytoma was removed. Post-operatively, he had no recurrence ten years later and he has had no convulsions. He continues to make financial errors so his wife "runs the show."

Case 2: A fifty-year-old man, who had been an alcoholic for years, was sent to a state hospital because of mental deterioration. He was disoriented for time, place, and person, was incontinent of urine and feces, but had no localized neurological signs.

The admitting diagnosis was "alcoholic psychosis." There was no documented history of head injury although most of the events in his life were not well documented, due to incomplete family and personal knowledge. He was in the hospital three weeks when he rapidly became stuporous. He was found to have papilledema, but no paralysis or other neurological signs.

Brain scan, arteriography, and craniotomy all confirmed a massive unilateral subdural hematoma. The patient was "cured" after neurosurgical intervention. He did not resume his consumption of alcohol and managed to return to and hold a job as a wheat farm worker.

Case 3: A fifty-eight year-old male consulting engineer ran his own firm successfully for twenty years. For reasons known only to him, he asked for premature retirement. Two

*An address presented at The Carrier Clinic, Belle Mead. Dr. Fisher is Chief, Department of Surgery at Muhlenberg Hospital, Plainfield, and Clinical Professor of Neurosurgery at Rutgers Medical School — CMDNJ, Piscataway.

years later, at the request of his wife he was seen by a psychiatrist because of poor memory. He had been wandering about aimlessly, walked in front of cars and needed constant companionship. On one occasion, he had become assaultive of a long-standing friend so psychiatric consultation was requested. He was sent to a mental institution where it was eventually noted that he was ataxic and incontinent and became progressively demented.

Neurosurgical consultation was requested to rule out a mass lesion. A cisternogram disclosed the technetium refluxed into the ventricle and the presence of a low pressure hydrocephalus. The CSF protein and pressure were normal, although the ventricles were enlarged.

A ventriculo-peritoneal shunt aided the patient. Incontinence, ataxia, mental function improved, but he did not resume his former demanding position.

Discussion and Review of the Literature

These three cases illustrate some of the problems in the differential diagnosis of psychotic behavior that can be exaggerated by the artificial barriers of psychiatry, neurology, and neurosurgery. The barriers should and can be broken if the responsible physician looks beyond his specialty and provides necessary diagnostic and therapeutic efforts for the good of the patient.

Brain tumor, subdural hematoma, and low pressure hydrocephalus are the common situations in which the primary or secondary level practitioner may make errors in diagnosis. Is there a way to aid our professional colleagues to avoid these errors?

Certainly a detailed history, physical, and neurological examination may indicate an organic rather than a "functional" disturbance. This obviously does not determine operability of the lesion nor guarantee that the surgery will aid the psychiatric aspects of the case.

The literature aids us in deciphering some of the important differences between operable lesions and non-operable intracranial lesions. Akelaitis,⁷ in commenting on a paper by Larson,⁷ made very cogent remarks:

"Mental symptoms may be the earliest and first manifestation of a brain tumor preceding neurological signs by months or even years. They may be schizophrenic, psychoneurotic, or manic-depressive.

"Very often the mental symptoms such as irritability, depression, or erratic behavior are determined by an aphasic difficulty which is interpreted as mental deterioration by the family and doctor, causing the patient to be committed. He may be confused with arteriosclerosis.

"Bilateral involvement especially of the frontal lobes may produce pronounced personality changes. Psychotic reactions are common and may resemble, very closely, functional psychoses, especially manic forms of behavior long before neurological signs or increased intracranial pressure."

Redlich, Dunsmore, and Brady,¹² before the great advances of arteriography, nuclear scanning, and computerized axial tomography, analyzed the errors in diagnosis of 100 brain tumors in 1948. They stressed that one must be "brain-tumor conscious" and likewise stressed that headaches, vomiting, and "choked discs" are not early signs of a brain tumor. They noted that little aid could be obtained by the observations of relatives or friends, that over one-half left the family practitioner dissatisfied and that many were labeled as having "nothing wrong" or were thought to be neurotic. Of the 100 tumors studied in the hospital, 29 were thought to have a brain tumor, 13 were thought to have a personality disorder, 13 epilepsy, and no diagnosis was established in 11. Cerebral arteriosclerosis was considered in 5. Ninety-four of the 100 were thought by consultants to have a brain tumor with the correct diagnosis being made. They found that 15 months seemed to elapse between the time the diagnosis seemed possible and the time the correct diagnosis was made. Some of the sources of diagnostic errors in the hospital were as follows:

- (1) Inadequate neurological history and exam27
- (2) False evaluation of personality disorder15
- (3) Seizures not explored14
- (4) Headaches not evaluated8
- (5) Failure to evaluate visual symptoms6
- (6) History of head injury overevaluated4
- (7) Overevaluation of hypertension4
- (8) Assumption of degenerative brain disease4
- (9) Overevaluation of alcoholic history2

(This is not the author's complete list.)

Of 8,600 admissions to a mental observation unit, Gooddy, Gautier-Smith and Dunkley⁴ found that five percent of the patients were cases of epilepsy, neurosyphilis, arteriosclerosis, alcoholism, strokes, brain atrophy, but very few (13 total) had brain tumors.

Olin and Weisman⁸ studied 475 brain tumors among 2,200 patients admitted to the psychiatric service of the Massachusetts General Hospital to determine how frequently psychiatric misdiagnosis might exist in early neurological disease. They stressed that the majority of patients with brain tumors displayed motor and sensory disturbance early, not psychiatric disturbances. They pointed out significant similarities between psychiatric illness and temporal lobe tumors such as anxiety, impulsive anger, and olfactory sensory disturbances.

Olin and Weisman⁸ emphasized that psychiatric syndromes consist of behavioral inhibition while those having neurological disease exhibit motor, sensory, and intellectual impairment. They noted that the psychiatric patient often adopted a special attitude or viewpoint toward his symptom which may be a significant part of the clinical disorder, while the neurological patient was baffled, but usually preserved objectivity about his symptoms. He suffered from impaired performance of individual acts and movements — his memory became defective and his social and emotional life was secondarily invaded. These authors stressed that visual and olfactory hallucinations, automatisms, loss of recent memory, and impaired abstract thinking are quite different from anxiety attacks, obsessional ideas, hypochondriacal preoccupations, and diminished self-esteem.

Blumer³ stressed that depressive, paranoid, manic, and catatonic reactions, approximately in this order of frequency, might be present in association with impaired cerebral functions. He also found hysterical or obsessive-compulsive reactions imbedded in the course of brain disease. Blumer stressed, as we all should do, the false dichotomy of organic and functional brain disease.

In a remarkable table, he listed the primary mental signs of cerebral impairment:

<i>Signs</i>	<i>Manifestations</i>
1. "Clouding of consciousness" (defect signs)	Impairment of: attention, coherent thinking, memory, orientation, slowness and easy fatigability of intellectual performance.
2. Release lower level mental activities (productive signs)	Hypogogic reveries, disquieting dreams, dream-like experience while awake, delusions, illusions, hallucinations.
3. Defective attempts at intellectual readjustment	Circumstantiality, perseveration, confabulation, suggestibility.
4. Characteristic affective response	Affective lability: rapid shifts from tears to laughter, anxiety to anger.
5. Disturbance of the wake/sleep regulation	Insomnia or somnolence.

We can agree with most of such statements, but we often find it very difficult to differentiate a brain tumor from deterioration of cerebral function associated with aging, medical problems, endocrine disturbance, or chronic alcoholism. It is consoling to realize that we have progressed since 1940 when a report of 233 autopsies at a state hospital disclosed 30 patients (13.5 percent) with a brain tumor.⁷ From this same hospital 16 years later, 78 brain tumors were found in 2161 autopsies or 3.1 percent,⁹ figures which are much closer to the average. The authors stressed that meningiomas, which are benign, operable, and curable were the commonest tumors found. Klotz,⁶ surveying patients hospitalized for chronic mental disorders, found that brain tumors associated with mental symptoms were bilateral and supratentorial, and involved the frontal and temporal lobes and corpus callosum. They were generally slow-growing (meningiomas, epidermoids, cholesteatomas, or oligodendrogliomas) and thus were favorable for surgical resection. Klotz⁶ felt that most brain tumors showed minor reactive psychological phenomena at some time.

Hobbs⁵ also stressed the point that meningiomas of the olfactory groove or oligodendrogliomas of the frontal lobe often caused psychiatric symptoms.

Rubert and Remington¹³ analyzed 30 years' experience at New York Psychiatric Hospital in

Syracuse for the reasons that patients with brain tumors come to a psychiatric hospital. They found that only 34 of 17,000 patients had a psychosis due to a brain tumor. The psychological signs and symptoms noted were:

Depression	8
Suicidal attempt	3
Aspects memory deficit:	
Confusion	7
Disorientation	4
Loss of recall	6
Assaultive behavior	5
Personality "changed"	2
Paranoid ideas	2
Agitated and irritable	2
Insomnia	2
Obsessional ideas	1

At times, the psychological symptoms were the only symptoms present; depression was the most common symptom noted. My personal experience, as in Case 1, has been with patients who are generally not assaultive, particularly when the lesion was in the frontal lobes. Mental deterioration, "witselsucht," hyperphagia, or loss of inhibition are the symptoms I have seen most frequently with meningiomas of the olfactory groove or sphenoid ridge. Gliomas of the frontal lobes certainly cause mental deterioration, but the literature infrequently stresses this, probably because of early neurosurgical consultation. Thus, the psychiatrist frequently is not consulted in such cases.

Williams and his associates,¹⁴ in a combined neurological, psychiatric, and neurosurgical unit found that the majority of 107 patients having neurosurgical problems had abnormal findings on physical examination or simple testing. Organic disease was recognized in 60 percent on admission and in another 21 percent during their admission. Of these conditions, 22 were primary tumors of the brain, 12 were subdural hematomas and seven each were subarachnoid hemorrhage and hydrocephalus.

Of 77 patients, 66 were confused or demented, or both; in most cases of dementia, there were associated personality changes. Hallucinations and delusions were common but presentations closely resembling functional psychiatric disease were rare.

Patients with subdural hematomas frequently are sent into a psychiatric facility. This is unfor-

tunate because chronic subdural hematoma may be a dangerous problem because of its paucity of signs and symptoms and the presence of mental deterioration. All too frequently this condition is found in alcoholics whose memory of head injuries may be clouded by their state of alcoholism.¹⁰ In addition, many of these patients have cerebral atrophy, either presenile or senile, and thus the subdural space is potentiated to accept any volume of blood from even the most minor blows to the head. A high degree of sensitivity may now permit recognition and successful treatment of subdural hematoma with reversal of the abnormal psychiatric status. There is no role for medical management of chronic subdural hematoma.

Allen, *et al.*,² as early as 1940, noted that 245 (7.9 percent) of 3100 consecutive autopsies in psychotic patients had a subdural hematoma as the cause of death. They stressed the fact that subdural hematomas are more common in the psychotic group than in the general medical population.

Our experience in a large university setting, which serves several state hospitals was that patients with subdural hematomas were admitted because of the mental deterioration. These patients were ultimately sent for neurosurgical intervention when they developed convulsions, stupor, coma, or papilledema. Occasionally, these patients were sent because of abnormal cerebral spinal fluid findings or abnormal electroencephalograms; infrequently, they were sent for a brain scan to rule out a mass lesion.

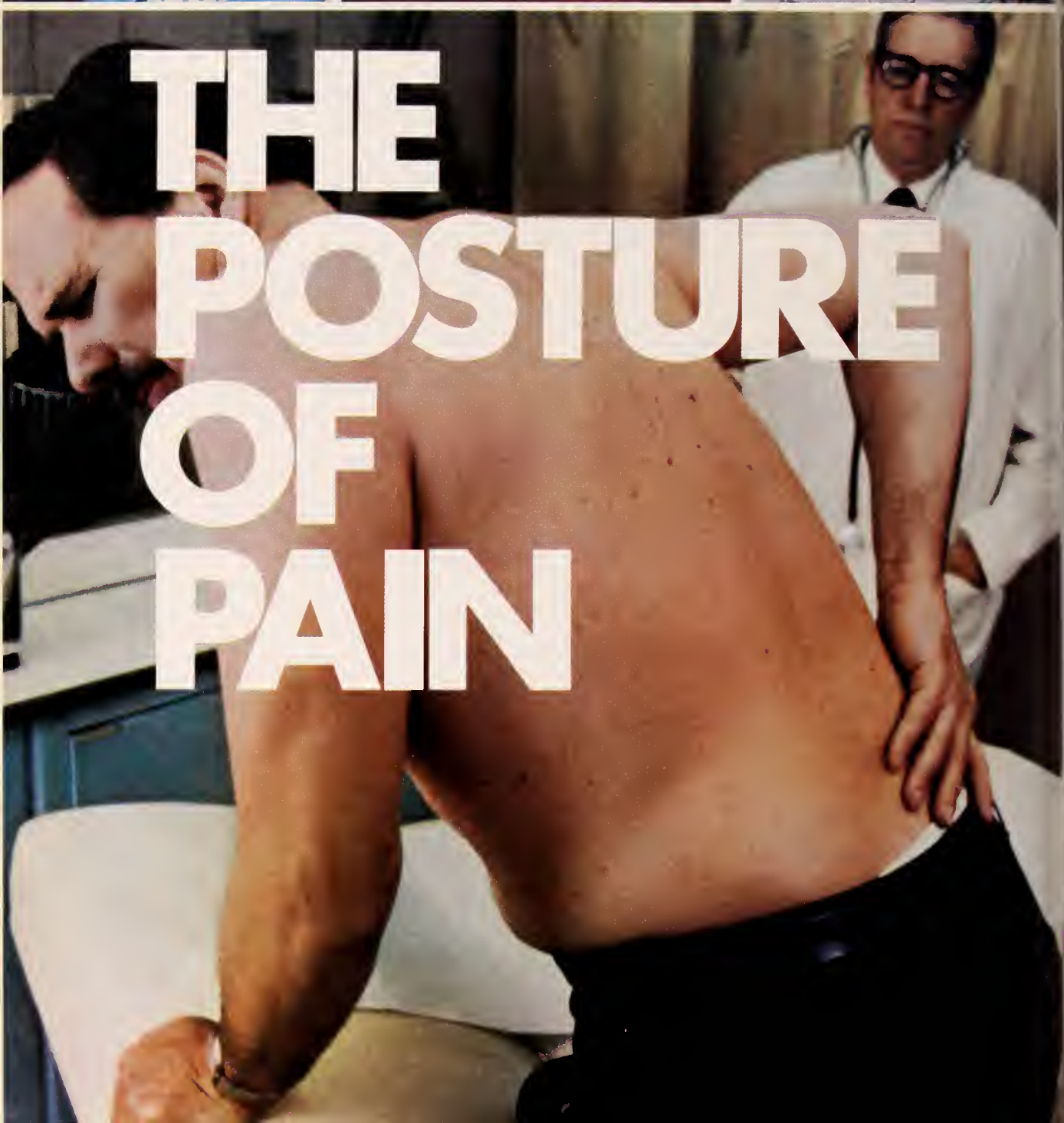
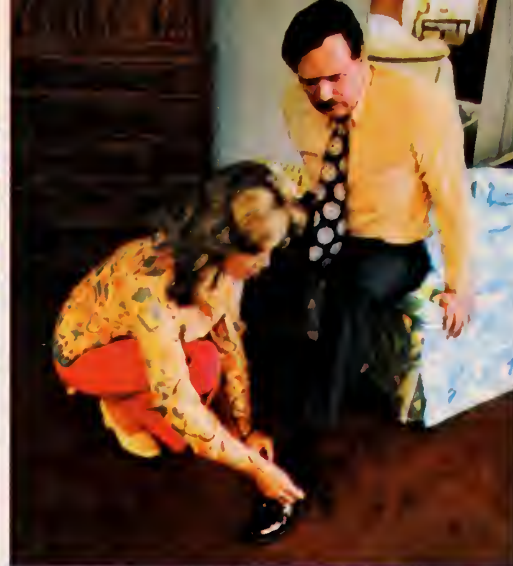
Low pressure hydrocephalus is a new diagnostic entity conceived by Adams and associates¹ and brought to a level of better understanding by the use of cisternography. This procedure consists of injecting a radioactive isotope, such as Technetium-99, into the lumbar cerebral spinal fluid and observing its flow into the subarachnoid space or the ventricular system. Should the Technetium reflux into the ventricular system, we believe the patient has low pressure hydrocephalus to account for the classic triad of dementia, ataxia, and incontinence of urine. Shunting of the cerebral spinal fluid may be (but not always) of value in reversing the psychological abnormalities.

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CASE REPORT

A case of jaw cysts and basal cell nevi syndrome, which was present since adolescence, has been reported. Multiple jaw cysts, rib anomalies, and extensive calcification of the falx cerebri were discovered on roentgenographic examinations. The patient developed anaplastic carcinoma of the left maxillary antrum when he was 55 years of age. The etiology of the basal cell nevi syndrome is unknown, but probably represents an embryonic primary germ layer dysgenesis. The findings in this case, together with the extensive review of the literature, suggest multiple manifestations in the spectrum of this syndrome. To our knowledge, no other case of anaplastic carcinoma associated with this syndrome has been reported.

Basal Cell Nevi Syndrome Associated with Maxillary Antral Carcinoma

**W. E. Matthey, M.D.,
M. Rothberg, M.D., and
P. Khorrami, M.D., Livingston***

The basal cell nevi syndrome is characterized by multiple nevoid basal cell epitheliomas of the skin, multiple cysts of the jaw, and congenital deformities. The syndrome is hereditary and involves systems and organs of both mesodermal and ectodermal origin. Because a number of common manifestations of this rare condition (jaw cysts, skeletal anomalies, calcification of the falx cerebri) are evident radiologically, the diagnosis may be suggested first by the radiologist. The purpose of this communication is to report a case with the first known anaplastic carcinoma of the maxillary antrum.

Case Report

A 55-year-old man with facial swelling was admitted to St. Barnabas Medical Center for diagnosis and treatment. As a teenager, he had multiple basal cell carcinomas of the face, hands, and arms. In addition, he began to develop dentigerous cysts involving the mandible and maxilla. Since his early twenties, he had multiple surgical procedures for excision of the basal cell carcinomas and for the dentigerous cysts of the mandible and maxilla.

Eight years prior to admission, additional surgical procedures were considered to be contra-indicated, despite recurrent involvement of the face and eyelids. He was then given a course of radiotherapy with subsequent atrophy of the skin and development of cataracts in both eyes. In the ensuing years, he developed only small areas of carcinoma of the skin and cystic changes in the mandible which were amenable to local surgical resection.

Two months prior to admission, he noted the onset of pain and swelling in the left side of the maxilla. Incision and drainage of what was thought to be an abscess was carried

out several times. Symptoms continued and he was referred to St. Barnabas Medical Center. It was noted the patient had a draining soft tissue mass overlying the left maxilla. The face and arms were studded with basal cell epitheliomas (Figure 1). Roentgenograms showed (Figure 2) multiloculated cysts in the mandible, destruction of the inferior orbital floor, and of the medial and lateral walls of the left



Figure 1 — Basal cell nevi on the face.

*From the Department of Radiology, St. Barnabas Medical Center, Livingston, New Jersey, where Dr. Matthey is Director of Radiology, Dr. Rothberg is Associate Attending Radiologist, and Dr. Khorrami was Radiology Resident. He is now Radiologist at Chilton Memorial Hospital in Pompton Plains.



Figure 2 — Multi-loculated cysts in the mandible.



Figure 4 — Calcification of the falx cerebri.



Figure 3 — Anaplastic carcinoma destruction of the left inferior orbital floor, medial and lateral walls of the left maxillary antrum.

maxillary antrum (Figure 3). Anomalies found on the chest x-ray were bifid ribs and on the skull x-ray extensive calcification of the falx cerebri (Figure 4). Other radiographic and laboratory studies were within the limits of normal.

At operation a large abscess cavity was entered and drained through a left sublabial incision. Obvious tumor was seen and biopsied. There was partial destruction of the bony walls of the maxilla. Histological examination of the specimen showed anaplastic carcinoma, spindle-cell type. Following surgery, there was rapid growth of the tumor and despite repeated surgery and radiation therapy, intracranial extension of the tumor occurred. The patient expired six months after admission.

Discussion

The basal cell nevi syndrome was possibly first reported by Jarisch in 1894.¹³ In the same year, White²⁰ reported a case which may be another example of this syndrome. In 1939, Straith reported a family with skin lesions associated with jaw cysts.¹⁷ The case reported by Binkley and Johnson in 1951 was a 31-year-old woman with basal cell nevi, dental cysts and agenesis of corpus callosum.³ The skin lesions appeared in childhood and jaw cysts were noted when she was about 16 years of age. Gorlin and Goltz⁹ and Anderson, McClendon and Howell¹ described a number of anomalies associated with cutaneous lesions.

In 1960, Gorlin and Goltz⁹ suggested the combination of multiple basal cell epitheliomas, jaw cysts and bifid ribs as a syndrome. The jaw cysts and basal cell nevi syndrome are congenital and are inherited as an autosomal dominant trait with marked penetration. This is a rare syndrome, and according to Gorlin, *et al.*, only 150 cases had been reported in medical literature up to 1965.⁸

Cysts of the mandible and less frequently cysts of the maxilla are very common findings in patients with jaw cysts and basal cell nevi syndrome. Cysts are usually multiple and vary in size from several centimeters; they frequently start at childhood with gradual destruction of bone. Microscopically, uninfected cysts are often covered by stratified squamous epithelium which in turn is covered by a layer of keratin.

Ameloblastic change is an uncommon complication which has been reported by Gorlin, *et al.*,¹⁰ Clendenning, *et al.*,⁷ and Maddox, *et al.*¹⁴ Fibrosarcoma of the mandible developed in a patient reported by Binkley and Johnson,³ however, this patient received x-irradiation to the mandible for seven years for treatment of the cysts. The first case of this syndrome reported by Howell and Caro¹² was a 59-year-old man who had multiple basal cell nevi for 40 years. At 30 years of age, sarcoma of the maxillary antrum was discovered and was removed successfully. Sarcoma has not been reported in other patients with this syndrome and should be evaluated by further study. To our knowledge, anaplastic carcinoma of the antrum, associated with jaw cysts and basal cell nevi syndrome, which was observed in our case, has not been reported in the medical literature. The association of chronic maxillary antral inflammation and repeated periodic irradiation that preceded the occurrence of anaplastic maxillary antral carcinoma may have played ominous roles in the eventual malignancy development.

Frontal and bi-parietal bossing is often observed giving the skull a pagetoid appearance.^{9,18} Broad nasal root association with hypertelorism (abnormal increase in the interorbital distance) is a common finding. Calcification of the falx cerebri, tentorium, and choroid has been reported by several authors. Skeletal anomalies

are present in approximately 75 percent of patients.⁸ The most common anomaly is bifid ribs, but other rib anomalies include synostosis, partial agenesis, and splayed ribs.

Kyphoscoliosis which has been observed by a number of investigators,^{6,9} had an incidence of 14 percent in the studies of Anderson, *et al.*¹ Spina bifida was noted by Anderson and colleagues with an incidence of 19 percent. Shortening of the metacarpal bones, especially the fourth, was seen by Gorlin, *et al.*,¹⁰ and Block and Clendenning.⁴ It was so marked in the case of Block and Clendenning as to suggest pseudohypoparathyroidism.

The basal cell nevi are generalized in distribution and any area of the body may be involved. There is tendency toward involvement of the central facial areas. They may occur in different varieties, i.e. pigmented, morphea-like, nodular, or ulcerated. Microscopically, the basal cell nevi cannot be differentiated from the basal cell carcinoma. Taylor, *et al.*¹⁹ reported two cases with direct extension of skin tumor into the brain and for this reason preferred the term "nevoid basal cell carcinoma." Metastasis to the brain and lung may also occur.²

The basal cell nevi usually start between puberty and the third decade of life. In six patients reported by Clendenning, *et al.*⁷ the onset varied from 14 to 35 years. In one case¹² tumors were noted at 6 years of age.

Milia have been reported frequently in patients with this syndrome.^{5-7,10,12} Comedones⁶ and dyskeratosis of the palms of the hands and soles of the feet^{5,7} are other skin changes. Epithelial and sebaceous cysts have been reported by some observers.⁷

Central nervous system changes, including mental retardation and schizophrenia, have been noted in several patients.^{3,4,9,13} The case reported by Binkley and Johnson was found at autopsy to have a partial agenesis of the corpus callosum. To our knowledge, no other cases have been reported with this abnormality. Congenital hydrocephalus is another finding associated with this syndrome^{10,11} and may be responsible for the frontal and biparietal bossing.⁸

Congenital cataracts were reported by Gorlin and Goltz.⁹ A patient with congenital blindness of the left eye was presented by Oliver.¹⁵ The relationship of this syndrome with other hereditary or congenital syndromes such as pseudohypoparathyroidism, Marfan Syndrome, Turner's Syndrome and Klippel-Feil Syndrome has been described by some of the investigators,^{4,8,10} and their significance should certainly be evaluated by further study.

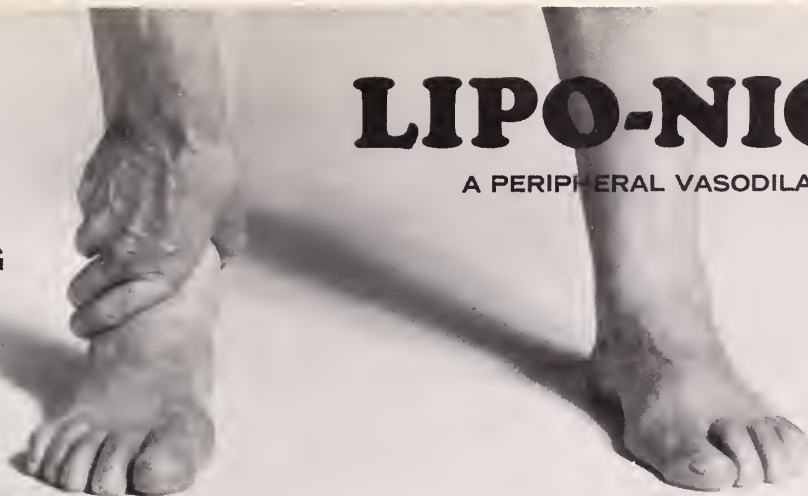
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IMPORTANT NOTE: INDOCIN (Indomethacin, MSD) cannot be considered a simple analgesic and should not be used in conditions other than those recommended. The drug should not be prescribed for children because safe conditions for use have not been established.

Because of the high potency of the drug and the variability of its potential to cause adverse reactions, the following are strongly recommended: 1) the lowest possible effective dose for the individual patient should be prescribed. Increased dosage tends to increase adverse effects, particularly in doses over 150-200 mg per day, without corresponding clinical benefits; 2) careful instructions to, and observations of, the individual patient are essential to the prevention of serious and irreversible, including fatal, adverse reactions, especially in the aging patient.

Contraindications: Children 14 years of age and under; pregnant women and nursing mothers; active gastrointestinal lesions or history of recurrent gastrointestinal lesions, allergy to aspirin or indomethacin.

Warnings: *Gastrointestinal Effects:* Because of the occurrence and, at times, severity of gastrointestinal reactions, be continuously alert for any sign or symptom signaling a possible gastrointestinal reaction. The risks of continuing therapy with INDOCIN in the face of such symptoms must be weighed against the possible benefits to the individual patient. Gastrointestinal effects may be reduced by giving the drug immediately after meals, with food, or with antacids. Use greater care in aging patients.

Ocular Effects: Corneal deposits and retinal disturbances, including those of the macula, have been observed in some patients on prolonged therapy. Discontinue therapy if such changes are observed. Ophthalmologic examination at periodic intervals is desirable in patients on prolonged therapy.

Central Nervous System Effects: INDOCIN may aggravate psychiatric disturbances, epilepsy, and parkinsonism, and should be used with considerable caution in patients with these conditions. If severe CNS adverse reactions develop, discontinue the drug.

Precautions: Blurred vision may be a significant symptom that warrants a thorough ophthalmologic examination. Patients should be cautioned about engaging in activities requiring mental alertness and motor coordination, as driving a car. Headache which persists despite dosage reduction requires complete cessation of the drug. May mask the usual signs and symptoms of infection; therefore, the physician must be continually on the alert for this and should use the drug with extra care in the presence of existing controlled infection. After the acute phase of the disease is under control, an attempt to reduce the daily dose should be made repeatedly until the patient is off entirely.

Drug Interactions: Although INDOCIN has not influenced the hypoprothrombinemia produced by anticoagulants, patients on anticoagulant therapy should be observed closely for alterations in prothrombin time. In patients receiving probenecid, plasma levels of indomethacin are likely to be increased and a lower total daily dose of INDOCIN may produce a therapeutic effect; increases in the dose of INDOCIN should be made cautiously and in small increments.

Adverse Reactions: *Gastrointestinal Reactions:* Single or multiple ulcerations of the esophagus, stomach, duodenum, or small intestine, including perforation and hemorrhage, with fatalities in some instances; rarely, intestinal ulceration has been associated with stenosis and obstruction; gastrointestinal bleeding without obvious ulcer formation; perforation of preexisting sigmoid lesions (diverticulum, carcinoma, etc.); rarely, increased abdominal pain in ulcerative colitis patients or development of ulcerative colitis and regional ileitis; gastritis may persist after the cessation of the drug; nausea, vomiting, anorexia, epigastric distress, abdominal pain, and diarrhea.

Eye Reactions: Corneal deposits and retinal disturbances, including those of the macula, have been observed on prolonged therapy; blurring of vision.

Hepatic Reactions: Rarely, toxic hepatitis and jaundice, including some fatal cases.

Hematologic Reactions: Aplastic anemia, hemolytic anemia, bone marrow depression, agranulocytosis, leukopenia, and thrombocytopenic purpura may occur rarely. Since some patients manifest anemia secondary to obvious or occult gastrointestinal bleeding, appropriate blood determinations are recommended.

Hypersensitivity Reactions: Acute respiratory distress, a rapid fall in blood pressure resembling a shock-like state, angioedema, dyspnea, asthma, angitis, pruritus, urticaria, skin rashes, purpura.

Ear Reactions: Hearing disturbances—deafness reported rarely; tinnitus.

Central Nervous System Reactions: Psychic disturbances including psychotic episodes, depersonalization, depression, and mental confusion; coma; convulsions; peripheral neuropathy; drowsiness; lightheadedness; dizziness; syncope; headache.

Cardiovascular-Renal Reactions: Edema, elevation of blood pressure, hematuria.

Dermatologic Reactions: Loss of hair, erythema nodosum.

Miscellaneous: Rarely, vaginal bleeding, hyperglycemia, glycosuria, ulcerative stomatitis, and epistaxis.

Supplied: Capsules containing 25 mg indomethacin each, in single-unit packages of 100 and bottles of 100 and 1000; capsules containing 50 mg indomethacin each, in single-unit packages of 100 and bottles of 100.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

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adjust dosage and duration to patient and disorder

Clinical success with INDOCIN (Indomethacin, MSD) often depends on proper dosage. INDOCIN has demonstrated efficacy at doses that range from 50 mg per day up to 150 mg and 200 mg per day. Doses above 200 mg are not recommended because they generally do not increase the efficacy of the drug.

Duration of treatment with INDOCIN must be individualized, based on the variable activity of the disease. The usual starting dose is 25 mg b.i.d. or t.i.d. for active stages of moderate rheumatoid arthritis. If the starting dosage is well tolerated, increase by 25 mg at about weekly intervals until a satisfactory response is obtained or until the total daily dose of 150 to 200 mg is reached.

If minor adverse reactions occur as the dosage is increased, reduce the dosage rapidly to a tolerated level and OBSERVE THE PATIENT CLOSELY. If severe adverse reactions occur, STOP THE DRUG.

As symptoms subside, decrease the dosage to the minimum effective level. When possible to maintain relief of symptoms without INDOCIN, discontinue its use.

For further details on dosage and administration, see full prescribing information.

MEDICAL HISTORY

Dr. Peter Middleton (? - 1781)

Emergence of American Medical Historiography

Harry Bloch, M.D., South Orange

Illness, part of mankind's history, contributed to shaping his environment and destiny. Inevitably medical history was recorded as physicians incorporated in their writings the beginnings of the craft and the lives, opinions, and work of healers of the past.¹

Hermippus and Histomachus lived about 350 B.C., were of a medical sect, the dogmatists, who opposed the Hippocratic school, and were authors of works in the history of medicine now lost. Andreas of Carystus (B.C. 210) wrote on many subjects including history of medicine. Celsus (B.C. 30 to A.D. 50), a Roman physician, who practiced in the most magnificent capital of the civilized world, was a pioneer in the history of medicine and a collector of ancient writings. Soranus of Ephesus (98-138 A.D.), the first specialist in diseases of women and children added an historical essay to his gynecological writings. Arabian-Islamic physicians studiously cultivated medical history: Jussuf Ben Muhammed (1162-1234) of Bagdad and, the most famous of them all, Muwaffik ed Did (1203-1273) of Damascus. The latter wrote a biography of distinguished physicians.²

Two very important contributors to the history of medicine in the 18th century were a Frenchman, Daniel Le Clerc (1652-1723) and an Englishman, John Freind (1676-1728). Le Clerc published an important, comprehensive work (1696) based on original sources from the creation to Galen (he included a cursory epitome of medical history to Theophrastus v. Hohenheim), Freind covered the period from Galen to the beginning of the 16th century in a reliable, conscientious work (1725) which is often quoted. Many Germans wrote medical history in the same period, but none was their equal. These included P.G. Hartmann, Salomon Cellarius, Johann Conrad Barckhausen, J.H. Schulze, and P.G. Hensler.²

American Medical Historians

Among American doctors, history of medicine was almost a terra incognita. In pioneer days medical students, trained by preceptors, had neither interest nor time to study the ancients. With the founding of the first college (1765), there was little leisure to add instruction in this subject to the medical school curriculum despite the presence of a highly cultured faculty. These products of intensive European education included John Morgan, Benjamin Rush, Adam Kuhn, and William Shippen, Jr.³ In 1748, Benjamin Franklin (1706-90), one of its founders, wrote a simple "Account of the Pennsylvania Hospital."

On August 14, 1767, the Governors of King's College, New York, received a letter signed by Dr. Peter Middleton and five eminent city physicians, all of whom were foreign school graduates. They proposed "... a medical school within the College for instructing Pupils in the most useful and necessary Branches of Medicine." This was realized and the six petitioners were appointed professors with Middleton in the chair of the theory of physic.⁴⁻⁶ After the war the name Columbia replaced King's and the medical school was renamed the College of Physicians and Surgeons in 1807. When the medical school was opened November 2, 1767, Professor Middleton delivered a scholarly "Discourse" published in 1769.⁷

Middleton's "Discourse" which Walsh⁸ thought had more reputation than content was proof of his classical scholarship, profound learning, professional talents, knowledge of medical history, and grasp of medical problems. He quoted scriptures, Greek and Roman philosophers, historians, and poets. His sources were probably Le Clerc's "Histoire de la

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Medecine" and J. Freind's "History of Physic." Although he lacked the tools of medical-historical research, he evidenced understanding of the structure of the country, the philosophy and social conditions of the times, and realization that medicine is part of human society. Thus he contributed to the history of his country and to the cultural development of the people.

Middleton wrote his manuscript with confidence in the future of medical education and science in America. In his address, he noted the need for a hospital in New York City, and its advantages to students and practitioners. In June 1771, Professors John Jones (1729-91), Samuel Bard (1742-1821), and Middleton were granted a charter to open the New York Hospital. The institution was destroyed by fire (1774) and reopened after the war in 1791.^{5,6,9}

Middleton extolled observation, experimentation, hospital facilities, a curriculum divorced from medieval scholasticism, and emphasized the unity of theory and practice of medicine. His "discourse" began with praise for those who made possible the establishment of the medical college "to improve the great art of healing, set the practice of physic upon a reputable footing, elevate the status of the physician, and expose imposters." He admitted the manuscript contained additions to render it "more entertaining" and to promote the interests of the institution. He followed with an historical survey of "Seminaries of Learning" promoted by "illustrious sages" and supported by good governments, and of travelling sages who wandered from country to country spreading their experience. Seminaries, he stated, contributed to medical knowledge and were founded in antiquity by Egyptians, Chaldeans, ancient Greeks, Cretans, Hebrews, Persians, Romans, British Druids, and Indians. The "Seminaries" in Cos gave the world Hippocrates; and those in European nations were distinguished for learning and encouragement of science. The ancients realized that health was affected by environment, seasons, rest, motion, clothing, and habitation, and that diet benefited from fire and use of milk. He compared meat diet with vegetarian, and claimed that infirmities exist more frequently with fermented drinks.

Primitive man made medical discoveries through trial and error and observing effects of "substances on brutes." Such experiments and learning he wrote, led to the immortal Harvey's discovery of blood circulation.

Middleton traced the "conveyors" of medicine and practice: heads of families who preserved knowledge of medicine; priests and philosophers of antiquity; Hippocrates who made medicine a distinct science; the healers of China, Japan, Siam, Tibet, Arabia, Africa, and Turkey; and the Indians of the American continent.

The revival of learning in Europe fostered improved methods and discoveries in anatomy, chemistry, botany, physiology, pathology, pharmacy and materia medica, which, he stated, emanated from "Seminaries of Learning." He paid tribute to the medical faculty of Philadelphia, the first in the British colonies.

Middleton proceeded to a series of admonitions to physicians before they engaged in practice; the student must acquire knowledge of disease and its remedies as seen with a preceptor or in a hospital; understand the theory and practice of disease; diligently study the writings of our predecessors; and possess knowledge of fundamental subjects. He exhorted practitioners to instruct youth; demonstrate correct conduct and ethics; study, observe, and experiment for the benefit of their successors; and to remember that the "Art of medicine instructs us in the method of preserving health when present, and in the method of preserving health when lost, or how to alleviate the inconveniences consequent upon health repair, when total cure cannot be affected."

Dr. Peter Middleton is remembered vaguely as a name by few physicians, and to many not even that. Yet, he deserves recognition. Middleton was the first American physician to write a history of medicine, although it added little to our knowledge. He was a classical scholar versed in Latin and Greek and familiar with the history of medicine and the evolution of ideas. He was aware of the influence of historical events, people, creeds, social-economics, wars, and pestilence on medical progress.¹⁰

Middleton arrived in New York shortly after he received a Master of Arts and Doctor of Medicine degree from the University of St. Andrews on February 2, 1752.¹¹ He had served the army of the "Pretender" as surgeon, which can explain his hurried departure from Scotland (this was also true of Dr. William Hunter of Rhode Island).¹² Middleton rapidly achieved success; he was recognized for skill and learning, and received an honorary degree from Columbia in 1768.^{4,13} He was active in the "Weekly Society of Gentlemen" where medical papers were read and discussed.⁵ In 1766, Middleton married a widow who died five years later. When he died on January 9, 1781, at about 75 years of age, an only daughter inherited a large estate and a valuable library. He left no record of his birth or ancestry.¹⁴ In 1755, Middleton served in the French and Indian War, and, as a reward, received five thousand acres of land on the Susquehanna River.¹² During the Revolution he was a Tory, fled to Bermuda, but returned to the British-occupied city in 1776.

Colonial Medical Education

In the progress of American medical education between the preceptorial system and the founding of medical schools, demonstrations and lectures to groups of students were provided. Thomas Cadwalader (1708–79), 22 years old, returned to Philadelphia from England in 1730. He gave lectures in anatomy and performed the first post-mortem examination in 1742. William Hunter (1730–1777) of Newport, Rhode Island, delivered lectures in anatomy from 1754 to 1756. W. Shippen, Jr., (1736–1800) returned to Philadelphia from Edinburgh in 1763, offered lectures on anatomy related to obstetrics and a course in anatomy for students of physic.^{6,9} Middleton, in 1750, collaborated with John Bard (1716–99) in the first dissection of a body (of a criminal) with injection of blood vessels for medical instruction. This was a major contribution to colonial medical education.^{4,5,8,9}

Middleton was an erudite teacher, practitioner, and author of a "Discourse . . ." that warrants a niche in American medical history. His was the first publication in medical history in the colonies. In 1791, Dr. Benjamin Waterhouse (1754–1846), first professor of medicine at the Harvard Medical School (1783), delivered an address before the Middlesex Medical Society that traced the history of medicine from Hip-

pocrates.¹⁵ He was a native American, and one of the most cultured and capable physicians in the new nation.¹⁶ John Shaw Billings gave lectures (1877) in the history of medicine at the Johns Hopkins University and at the medical school (1893), with Welch, Osler, Kelly, Halsted and some others. This constituted the first significant impetus toward the progress of medical history in America.

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General John Sullivan in New Jersey

Doris P. Shalley

Washington Crossing, Pennsylvania*

After the American defeat at the brutal battle of Long Island in August, 1776, George Washington and the remnants of the main body of the Continental Army retreated across New Jersey. In hot pursuit, the ruthless British and Hessians devastated the countryside — plundering and burning. Washington and his ragged men, reduced to a meager 3,000, eluded the British General, Charles Cornwallis, and escaped across the Delaware River into Bucks County, Pennsylvania, early in December.

Another section of the rebel army was stalled near Basking Ridge, because its commander, Charles Lee, arrogantly ignored Washington's dispatches to join the main force. When Lee allowed himself to be captured, the responsibility for his troops was shifted to his second-in-command, John Sullivan.

A darkly handsome, hot-tempered, New Hampshire lawyer, General Sullivan was one of Washington's most dependable and active commanders, although not as celebrated as many other Revolutionary generals. Determined to lead Lee's command to Washington's camp, Sullivan pushed ahead through the Jerseys; to outwit British traps, he zigged and zagged from Basking Ridge to Phillipsburg. There he commandeered ferry boats, canoes, and dories, and crossed the Delaware on December 15th. Sullivan's original plan to reach the river by way of Pennington was thwarted when he was warned that Cornwallis had established his headquarters there and the area was patrolled by "crack troops." Five days after the crossing to Easton, Sullivan reported to Washington at the Bucks County camp.

Sickness on the March and in Camp

By the time Sullivan reached Pennsylvania, only 2,000 of Lee's original command of 7,000 men remained. Disease, desertion, and exposure had taken their toll, with high-level officers struck down as severely as the enlisted men. "Most of our Brigadiers are laid up," Washington

reported to the President of Congress on December 20, "not one has come on with the division under General Sullivan but (are) left sick at different places on the Road," he added. Small wonder! Conditions on the march and in the camp were hardly conducive to good health, so Sullivan, in common with other generals, had to cope continually with sickness. The men were in constant need of food and rest; sanitary conditions were deplorable. The resistance of the ill-clothed soldiers, especially in bitter cold, was low and disease spread rapidly. Typhoid fever, sometimes called "camp fever," was the most vicious killer. Some of the men had worn their clothes for months with no change. Soleless shoes (or no shoes at all) caused pitifully sore feet and bleeding, broken, scaly skin. Rags and other makeshift arrangements to protect the feet were hardly adequate for they bloodied on the march and stuck fast. The scant army diet was often reduced to rice and corn meal. As a result, one of the most insidious medical problems was loose teeth and the whitened, sore gums that come from poor nutrition. Frostbite was a deadly menace in the winter: soldiers who stopped to rest sometimes froze to death. An added hardship was the emotional strain from the ever-present enemy pursuit. Despite all of the suffering and distress, the rebels trudged on.

Medical Care

Army medical care left a lot to be desired; some said that the soldier had a better chance of surviving on the battlefield than in the hospitals. What qualified doctors there were tended toward amputation as a remedy for wounds, and "cure-alls" such as "calomel, julep, nitre elixir, vitric, Peruvian bark, and Virginia snake root were dispensed for everything from smallpox to pneumonia." Sometimes the women who invariably accompanied the troops served as nurses, while soldiers were assigned orderly duty. At best, treatment and care were haphazard.

Three of America's foremost physicians — Benjamin Rush, William Shippen, Jr., and John

*Mrs. Shalley is a free-lance writer residing in Washington Crossing, Pennsylvania.

Morgan — were in charge of the Continental Army's medical division at one time or another. Their abilities as doctors were first rate for the time, but personal feuds and political bickering cut down substantially on their effectiveness as army administrators. It is likely that Rush and Shippen came in person to Washington's Pennsylvania camp, although the commander favored Shippen. Shippen's writings indicate that he ran into General Sullivan's troops on their march through Bucks County. On December 17 he reported: "I saw about 4,000 of General Lee's troops . . . , marching from Easton, about two days (distance) from General Washington; all were in good spirits and much pleased with their General Sullivan."

The Christmas Attack

It was a gloomy camp indeed. Fear of British attack, the drastic reduction of his troops by illness, and termination of enlistments at the end of the year, caused Washington to risk all on his dramatic Christmas attack plan. He would gather a force of toughened regulars (about 2,400 men), cross the Delaware, march to Trenton, and surprise the British post which was manned by hard-bitten Hessian professionals. The army would advance together along Bear Tavern Road, and then split into two sections. The route of the left wing, headed by Nathanael Greene, followed Scotch Road until it merged with the Pennington Road, and thence to Trenton. John Sullivan was chosen to command the right wing. He would lead his troops down the River Road (not today's River Road, but slightly inland) and enter Trenton on the south, along what is now called Sullivan Way.

That Washington's plan succeeded is one of the miracles of warfare. In the most bitter weather — cold, sleet, snow, wind — the Americans crossed the ice-clogged Delaware, accomplished the ten-mile march in the frozen mire, and defeated the astonished Hessians. Over 1,000 Hessians were killed, wounded, or captured, while the Americans lost only four men. Sullivan had conducted his role with daring and intelligence.

After their return to Pennsylvania, the elated Americans could not celebrate for long. Washington recrossed the Delaware, planning to strike what he assumed to be his weakened

enemy at Trenton. Again he counted on Sullivan and his seasoned soldiers for support. Washington did not realize that Cornwallis was on the move to reinforce the Trenton garrison in the week between Christmas and the New Year. Almost captured in a British trap, he avoided disaster by secretly moving his army out of its Trenton position. On January 3rd, he encountered the British rear guard at Princeton, and in another notable battle, defeated the British.

Despite the fact that the army was exhausted, it was time to move into winter quarters. Washington, accompanied by Sullivan, pressed on to high ground at Morristown and made camp. The American victories had given the cause new hope and forced the British to abandon almost all of New Jersey.

After New Jersey

John Sullivan continued his career with distinction: Valley Forge, Newport, and a masterful campaign against the Iroquois that destroyed the Indians' power. After the Revolution, Sullivan continued his role in public life, as governor of New Hampshire and as a supporter of the ratification of the Constitution. Of all the achievements in Sullivan's noteworthy life, however, none was more outstanding than his contributions to the New Jersey campaigns.

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General Sullivan Road, Washington Crossing, Pa.

The Problem Patient in Your Waiting Room

Richard W. Roukema, M.D., Ridgewood

An experienced doctor approached me and asked: "Tell me, what do you do with the problem patient in your waiting room. For instance, when I see Mrs. Smith's name on the list of patients to see for the day on my schedule, it upsets me for the rest of the day. She is so difficult to deal with. It really would help me a lot if you psychiatrists would tell us how to deal with these troublesome patients."

This short conversation got me thinking about the common types of troublemakers that we all see in our practice; people whom we help, or do not help, depending upon our orientation and our time. Consider the following common types:

1. *The Listmaker* (The obsessive-compulsive person) — This individual has a behavior pattern characterized by severe rigidity. He's usually over-conscientious, over-dutiful, and unable to relax. He makes long lists of symptoms and adheres strenuously to every instruction that you give him, sometimes to the point of over-taking medication long beyond the point that is necessary. Typically, he'll come into the office with an extensive list of questions that he dutifully has listed so that he will not miss a single question. Meanwhile your waiting room is full of patients and you're late for your rounds at the hospital. As you see the list being carefully drawn from the patient's pocket, you heave a sigh and don't know what to do. Should you just endure?

Suggestion: Tell the patient that you are very interested in his questions and at a more propitious time you would like to look over the entire list. However, at this time ask him which two or three questions on the list bother him most. This helps him to concentrate his concerns and get at the bottom line of what is really troubling him at the moment, leaving other things — like his constipation and how many aspirins to take in case of a headache — to a later date. The obsessive-compulsive will usually

appreciate your problem with time since he is always obsessed with time himself. However, he also will be delighted with your taking an interest in reading his list at another time, so be certain to show some concern about it in the following visit. He will be a "dutiful" patient and will be gratifying, if you learn how to use his obsessive-compulsive traits in the service of your treatment instead of trying to fight his rigidity.

2. *The Actress or Actor* — This is usually considered the hysterical type personality. This patient enters in a very dramatic fashion: overly excited, overly emotional and unstable, with a tendency to be extremely dramatic. There is a good deal of attention seeking in this character, who often has a seductive quality. Once you are aware that you are dealing with such a person, several things become apparent. First one should reassure the individual that whatever needs to be done medically will be done, and that required inquiries will be made, needed tests performed, and everything done to get at the root of the problem.

The hysterical personality becomes extremely forgetful because of his overreaction with the excitement of the moment. Therefore, if you give such an individual instructions as to what to do at home, he probably will forget the instructions and call you five minutes after returning home. Consequently it is a good idea to write all directions on your prescription blank for the hysterical personality. For example, the pediatrician's directions to a hysterical mother, whose infant child has her first case of tonsillitis, will become obscured within minutes after leaving the office. It is highly advisable to write out such directions so that you are not called at 2 a.m. and asked whether the temperature was 101° or 102° when the aspirin should be given. This may save you valuable sleep.

The hysterical personality usually has a seductive nature. The doctor easily can fall into a

"transference" relationship with such a person. When this occurs, the patient "transfers" onto the present relationship with the doctor feelings and attitudes from the past which the patient has had with significant people in his life, including father, mother, siblings, lover, and so on. The patient will react to you and try to satisfy maternal, paternal, or erotic needs. Hence, emotional reactions to the physician are intensified and exaggerated. As a result, the patient will become overly familiar and overly attentive to the doctor and will ask questions and get involved in his personal life. He often wants to call the physician by his first name, which should be a clue to beware of the seductive nature of the relationship. It should be emphasized that these patients are often unaware of their seductive character. The hysterical person also tends to aggrandize the doctor and put him on a pedestal. A male physician may be very flattered by an attractive woman with an hysterical personality. She may try to give him the impression that he is the finest physician who has walked the face of the earth since Hippocrates. Pediatricians, obstetricians, and psychiatrists frequently fall prey to the seductions of the hysterical personality. When it becomes obvious to you that a patient is reacting in this way to you, it must be made clear to the patient that you intend to maintain the relationship on a professional level and not on a social basis. It is best not to become overly familiar. Answers to questions about one's personal life can be kept brief and simple or not answered directly. One might ask the patient why he is inquiring about your personal life. If a patient is too fond of you and wants to visit too often, you may have to risk the patient leaving you when you state *firmly* that frequent visits are not necessary.

3. *The Demanding One* (The aggressive personality) — This individual is extremely aggressive and hostile and demands immediate gratification in a relationship. He usually can disturb the waiting room in very short order. He comes in demanding to be seen immediately because of his rigid and important schedule, which leaves no time to wait for other people. Meanwhile, your waiting room is filled with people who have waited for weeks for appointments and your aggressive patient is there demanding immediate attention!

The first question should be: "Do you really want to keep such a patient if he is constantly going to be demanding?" If this is his first occasion, it would be well to reflect a bit on your own ability to handle aggression. If you tend to be a passive person or a good listener, you might want to defuse the individual by listening briefly to his demands and then asking him to wait anyway. If you are a more volatile personality, your style might better be immediately to tell him to wait and not give him a chance to recite what's on his mind. He may choose to do so, or to go somewhere else for service. In any case, the demanding personality cannot be dealt with lightly. He must be met firmly and aggressively by the physician. This takes some practice for people who are more passive by nature. I know of no better way to handle an aggressive individual than to meet him with firmness after a short period of listening and, if necessary, to use your own aggression to handle him. You have to decide the rules of the game in your office. No patient should be in a position to push his weight around and to demand service when other people, perhaps in greater need, are there. If you allow the aggressive individual to usurp your time and energy, he will continue to do so and your future with him will be assured: you will regret the day you took him on as a patient!

4. *The Helpless One* — Patients in this category are often the passive dependent type; some have an asthenic personality, while others are classified as the inadequate personality. The passive dependent individual is one who is given to extreme passivity, pouting, obstructionism, procrastination, and stubbornness. The inadequate person is generally ineffectual in his relationships both in social, emotional, and intellectual ways. He is inept, uses poor judgment, does not adapt well, and generally performs poorly. The asthenic individual is characterized by extreme fatigue and low energy level and is not able to enjoy life very much. He is generally overly sensitive to stress. Group these three types together because they tend to be quite helpless and often demand a great deal more time from the physician than normal individuals. They need considerable *reassurance* through "supportive psychotherapy," which need not take a long time. Firmness, *simple* instructions and *simple* advice often are necessary

to help these individuals along with their lives. Truly, they look to physicians as "father figures" and as people who help them in some of the practical aspects of life. The danger that the physician runs into here is responding to these individuals as though he were a "God-like" figure. One should avoid trying to answer such questions as: "Should I change my job? Should I get a divorce?" The physician has no right to answer such questions without considerable time for investigation. If such questions continue to appear, one would do better to refer the patient to a psychotherapist.

5. The Doubting Thomas — This is the individual who tends to have a very suspicious personality. Sometimes he is called the paranoid personality. He is quite rigid, hypersensitive, and envious and tends to blame others for everything that happens. He usually ascribes evil and sinister motives to others. The "doubting Thomas" will doubt your diagnosis. It is a mistake to try to prove to him that you are right and he is wrong. After all, when all tests indicate that the patient has an acute abdomen and needs immediate surgery, it is difficult to prove this to a patient. Scientifically, you may have all the indicators, but in his suspicious mind he will suspect that you are out to capitalize on his pain and to make money to pay for the new car that you just bought. If you try to prove to him that a tender abdomen coupled with an increased white count and fever indicate an operable condition he still will not believe you. In these instances, it certainly is very helpful to enlist the aid of a family member if at all possible. Hopefully, the relative will not be as suspicious and often will be able to convince the person to accept the necessary treatment. On the other hand, if the suspicion persists, one should not just speak firmly to such a person, but should sound off harshly. This is usually the only communication that the paranoid personality understands. If someone is overly solicitous, tries to explain too much, and ingratiate himself to the patient, a paranoid personality will only become more suspicious since he is *wondering why you are being so nice to him!* The best way to handle the paranoid personality is to be firm, and then somewhat harsh and even nasty, if necessary, telling him to leave and seek another doctor if he does not want to take your advice. Upon doing

so the patient is more likely to go along with what you prescribe than if you are overly solicitous of him. You also will be starting out on a better footing for subsequent visits.

6. The Up and Down Personality (The cyclothymic personality) — There are a surprising number of individuals who, at times, are in an elated mood and other times in a depressive mood. If these mood-swings vary enough the name "cyclothymic personality" is given to these individuals. If you have never met such an individual, you may encounter him at either end of the scale, either in an elated period or a depressed period. Let us suppose the first meeting with such a patient is in his elated stage. He comes in and you diagnose a condition which requires immediate attention. His first statement to you will be: "Look Doc, I only came in here for some medicine for the cough. I don't need to go to the hospital. I don't have pneumonia or lung cancer. I just have a little cough and I think you're making too big a deal of this. I'll be all right in the morning with a good night's sleep." Such a tendency to minimize the problem is characteristic of the elated individual. At these times, he may be extremely ambitious, get very little sleep, be overly optimistic and have a high energy level. He will be very difficult to persuade to get help. Again, considerable firmness is needed with such an individual and sometimes to the point of being gruff. You even may have to exaggerate the seriousness of the illness: "If you are not treated you may die." The enlisting of his family members is also extremely important.

At subsequent times you may meet this individual when he is in a depressed period. He will be overly concerned with such minor preoccupations as constipation. He will be very worried and extremely pessimistic. He will have little ambition and will believe he has a serious disease such as cancer. You are now confronted with the problem of how to talk with an individual who is depressed. Generally speaking, a "pep talk" is not only useless, but the depressed patient will get the impression that you simply do not understand him at all. *He does not like to be told that he has nothing to worry about and does not want his symptoms minimized. He feels his symptoms very deeply so the worst thing you*

can do is to minimize them, give him a "pep talk" and send him on his way with a prescription for a laxative.

A much more successful way of talking with a depressed person is to deal with him on his level. That is, one must appreciate the depths of his depression first before being able to help him. An appropriate response might be: "You certainly are low today. You must feel very badly. It must be awful to feel as depressed as you are today"; or, "I can see that you are really low. It must be awful to be that depressed." Having thus established at least a base for the patient's feeling level it then makes sense to say: "We (meaning the patient and you) will do all we can to help you feel better and will start with the following." You can then tell him what you specifically have in mind to do and also prescribe an appropriate anti-depressant agent. Don't forget about suicide. When a doctor sees someone who is deeply depressed, it is not a wise thing to come out directly and ask whether the person is suicidal. A more inclusive way of inquiring into suicidal intent is to ask the question: "Have you ever felt so low that you thought you might want to *harm yourself in any way*? This

includes a multitude of transgressions. For example, it includes the adolescent toying with the idea of suicide by scratching his or her wrist with a sharp instrument. It includes taking five aspirin in a manipulative attempt to scare people and it also includes serious suicide intent. This question may even elicit answers regarding a patient's harmful drinking habits or other behavior patterns. Needless to say, if serious suicidal intent is mentioned by a patient or observed by a physician, this individual promptly should be referred to a psychiatrist.

Summary

The above outline of personality types certainly does not cover all the possibilities. However, they are commonly seen in every physician's office. If you become skilled in learning how to handle these individuals in accordance with their personality inventory, your medical practice can become much easier. Instead of the patient becoming the reason for a bad day, he may become a challenge to deal with more successfully. Gaining control of the interpersonal relationship between you and your patient will certainly make you feel more confident and more "on top of things."

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Behavior Change through Patient Education and Contracting*

Lanny E. Morreau, Ph.D., Normal, Illinois

While patient education has received a great deal of attention among health professionals, numerous problems continue to appear in educational programs. These deficiencies often result from basic fallacies underlying program development, including assumptions that:

Individuals who enter a program represent a homogeneous population ready to complete the same materials and absorb the same level of information;

Individuals who complete a given program necessarily have acquired the knowledge and skill to apply new information in their everyday lives;

Individuals are intrinsically motivated to change existing behavior or to acquire new behavior;

Individual patient involvement need not be considered when prescribing educational programs.

While few educators would agree with these premises, the procedures followed in many programs provide ample evidence of their application. Such educational programs are characterized by large group instruction on general topics; presentation of information through a single mode, such as oral presentation; the use of standard educational material which all patients complete; the absence of formal recorded evaluations of patients before, during, and after the program is completed; the absence of planned reinforcement for progressive changes in patient behavior; and lack of patient involvement in the instructional process. The presence of any of these variables in an educational program can adversely affect patient progress.

Patient Behavior and Contracting

Patient behavior can indicate whether

deficiencies exist in educational programs, and an analysis of the behavioral problems frequently cited by patient educators clearly provides a direction for the development of an effective educational system. For example:

Consistent patient refusal to participate in, or withdraw from, an educational program may indicate a lack of motivation on the patient's part or a lack of relevance in the material presented to them.

Poor patient performance on progress checks may indicate inadequate preparation for working in a given area, inadequate materials, or inadequate alternatives for instruction.

Incorrect performance of procedures by patients may indicate the need for more systematic progress checks to determine errors before they are learned.

Apparent lack of progress or understanding by patients of why they're "doing things" may indicate a lack of specific objectives in the educational program and procedures for patient involvement.

Failure of patients to follow through on health care procedures outside the clinical setting may indicate the absence of procedures which generalize behavior from the learning situation to the everyday setting.

Doubt on the part of the health-care team as to where to begin instruction may indicate the absence of effective pretesting procedures.

*Presented at the Conference on Diabetes Education and Management (March 1975) at Rutgers Medical School, CMDNJ, Piscataway, sponsored by the Office of Consumer Health Education, NJCMD-Rutgers, the New Jersey State Department of Health, and the Ames Company. Dr. Morreau is an Assistant Professor at Illinois State University.

The health-care team's inability to define clearly at any given time what a patient has mastered, what a patient is working on, and what skills a patient needs to acquire may indicate the lack of an adequate recording and "follow-along" system.

Based on these limited examples it becomes apparent that an effective patient-education program must include:

- Clearly defined goals and objectives
- Procedures for involving patients as members of the health-care team in defining educational programs
- Objective-based pretests, systematic progress checks, and evaluation of the patient's mastery of skills in an everyday setting
- A variety of teaching materials for meeting a given objective and alternative models for presenting information to patients
- Procedures for reinforcing patients for progress toward self-management
- Procedures for following and recording client progress on program objectives

Developing an educational system that meets these specifications may appear impossible given the number of variables to consider. The quandary can be resolved through the use of a *performance-based contracting system* which consolidates these variables, considers individual needs, and provides a basis for effective program development.

A contract is a non-legal, written agreement between the patient and professional health-care team members which defines the specific outcomes to be derived from instruction — that the patient will be able to inject insulin, select foods according to a prescribed diet, and carry out all of those behaviors that, as a composite set, represent the skills needed for self-management.

Patient Involvement

Calling for "agreement" between the patient and the professional health-care team, contracts facilitate patient involvement, both in es-

tablishing immediate objectives and in the instructional process itself. In contracting, the patient receives and discusses a contract containing clearly-stated objectives, a rationale for why he should be working toward meeting those objectives and a description of the procedures and the health-care team involvement he can anticipate. This approach represents a completely different level of patient involvement than the traditional educational procedure of assigning him to a program and assuming that a staff member will inform him of the various roles, responsibilities, and objectives.

Goals and Objectives

Because contracts are based on patient performance, they must include behaviorally-stated objectives and measurable standards for evaluating performance. If, for example, the goal of patient education is to teach the patient the skills necessary for relative self-management, it is necessary for the professionals on the health-care team to specify those behaviors which, when demonstrated at a mastery level, indicate that a patient has become relatively self-managing. To be useful for contracting, objectives should include the exact behavior we anticipate from the patient ("the patient will pull the plunger on a syringe"), as well as the conditions under which the behavior will occur ("given an assembled syringe in the presence of a nurse"), and the criteria by which the performance will be evaluated ("to a prescribed insulin dosage with 100 percent accuracy"). Properly written, this objective states: "Given an assembled syringe in the presence of a nurse, the patient will pull the plunger on the syringe to a prescribed insulin dose with 100 percent accuracy."

Arranged sequentially — in the order in which they are to be learned — such objectives provide a basis for developing pretests to determine what skills the patient already has and where, on the continuum of objectives, instruction should begin. Gearing instruction to a previously established set of objectives also aids in selecting educational materials and in reinforcing patients for acquiring specific skills. Both the patient and the health professional know exactly what behaviors will be taught and what is expected from the other.

Since most programs have relative self-management by the patient as a common goal, it is unnecessary to create and sequence new objectives each time an educational program is developed. A comprehensive list of objectives has been prepared by professionals in a form suitable for use in patient contracting.**

Contracts based on a comprehensive list of sequential objectives also provide for program monitoring, since both the patient and the health professional can indicate on the list when they have completed their respective tasks involved in meeting a given objective.

Evaluation Procedures

All diabetics do not come to an educational program with the same ability to manage the disease. Thus they may not be prepared to work toward the same objectives, to begin at the same point in an instructional program, or to profit from the same set of materials. Using a set of sequential objectives leading toward self-management, the health professional can pretest patients to determine where their performance matches the objectives, identifying those skills the patient has already mastered and beginning a program at that point.

Behavioral contracts also define the points at which the patient's progress will be evaluated — how well the patient performs as he progresses. If the professional health-care team has no means of checking progress other than informal procedures, the patient may repeat errors without realizing he's making a mistake, and without our correcting it. Mastery of each objective agreed upon in the contract should be demonstrated before continuing to the next objective.

In addition, by reviewing the composite set of objectives, the health professional can designate where cumulative progress checks should occur (demonstration of mastery of related skills). Where possible, much progress checking should be done by patients (self-check), who evaluate their own procedures in terms of precise criteria and proceed on their own — a major step toward independent functioning outside the clinical setting.

Individualized Materials

Competency-based contracts not only define what needs to be taught, but also place constraints on how teaching should be structured. While large-group instruction is relatively economical, it ignores individual differences in learning skills, such as reading ability; in the level of prior knowledge; and in the pace at which learning occurs. While individual staff-patient interaction is required for learning some skills, programed instruction can be used to *individualize* teaching where direct staff-patient involvement would be unnecessary and impractical.

Contrary to popular thinking, programed instruction does not always mean the presentation and completion of a programed text. Programming involves the presentation of sequential units of information — not necessarily small — to which the patient can respond and receive feedback on the accuracy of his response. For example, if a contract calls for the health professional to teach a patient how to select a diet based on his needs, we might ask the patient to read a selection on diets, respond to questions related to the selection, obtain feedback by checking the answers against a key, demonstrate knowledge by preparing a menu, and receive feedback from the dietitian who checks the menu when it is completed.

Programs designed in this way have the potential to conserve staff-time, provide feedback to the health professional and the patient on a systematic basis, and indicate the patient's progress and eventual success in meeting prespecified objectives.

Motivation

Seeing one's progress across a set of clearly specified objectives, such as a contract, may motivate patients to continue to engage in program activities — success, in itself, is highly reinforcing. The attention, interaction, and approval provided by health professionals in agree-

**This is "Guidelines for the Diabetes Health-Care Team," from *Education and Management of the Patient with Diabetes Mellitus*, 1974, published by Ames Company, Division Miles Laboratories, Inc.

ing to a contract and in teaching may provide additional incentives for patients — attention and approval are powerful reinforcers.

The contracting procedure, however, has the even greater potential for providing reinforcing consequences on a systematic basis to motivate patients toward behavioral change. While agreeing on successive, small behavioral units (objectives) to be accomplished, tasks to be completed, and mutual responsibilities while working toward objectives, the health professional can also systematically reach agreement with the patient as to positive consequences to be provided upon mastery of each task. It has been demonstrated clearly that individuals tend to work toward objectives that have a “pay-off” for them. The contract allows us to specify when and what positive consequences will be provided for immediate task completion as well as for long-range goal achievement.

Further, because contracting requires direct staff/patient interaction, the health professional has the opportunity to identify specific reinforcers based on individual characteristics. Rather than assuming that all patients are motivated by the same things, motivation can be based on the observed or discussed behavior of patients. Patients can participate in the selection and management of personal reinforcers.

This procedure provides a positive alternative. Motivation has often been disregarded or mismanaged in patient education programs under the assumptions that: The health professional's role is to provide instruction, not incentive, although instruction without incentive is meaningless; patients will develop new skills on their own; the “obvious” advantages of being able to manage a chronic disease will be obvious to patients; and punishment — ignoring, criticizing — because it *seems* to work, is an effective motivator for patients. In contrast, contracts provide for *planned, positive* consequences based on individual patient needs — consequences that lead to more than simple participation in programs, but to behavioral change as a result of the instruction.

Program Evaluation

In addition to meeting the ongoing needs of the

patient and other health-care team members, a systematic approach to patient education should be self-correcting. Patient success indicates program success; patient failure can be viewed as a source of information for program improvement. If a patient performs unsuccessfully, we should ask:

- Was the patient involved in establishing the content of the contract?
- Was the contract clear — written in terms the patient can understand?
- Did the contract call for accomplishment rather than obedience?
- Were the items on the pretest matched to the objectives for the program?
- Was the patient's educational program based on the objectives indicated by the pretest?
- Should the program have been started at a different point on the objectives' sequence?
- Were the materials/activities adequate for meeting the specific objectives?
- Was the mode of instruction appropriate for the individual patient?
- Were the tasks too large or too difficult for the patient to perform?
- Was a reinforcer identified? Was it provided after successful completion of small steps?
- Was the contract fair? Was it adhered to?

Only through continued analysis and refinement can we arrive at optimal programs for patient education — programs in which both patients and the health-care team play an active role in the educational process. With the mutual cooperation and participation they encourage, as well as the systematic approach they require, individualized, performance-based contracts can provide an effective basis for both immediate instruction and long-range program development.

Note: A second presentation from this Conference will appear in the December issue.

Prepaid Health Care and The Medical Society of New Jersey*

Interest in prepaid health care is increasing. Health Maintenance Organizations (HMO) and Individual Physicians Associations (IPA), in various stages of development, exist in Hudson, Essex, Burlington, Middlesex, Mercer, Morris and Cumberland counties, with contiguous parts of other counties involved. It is apparent that The Medical Society of New Jersey should examine this subject, and the possible benefits of such "alternative" systems to the citizens of our State. A resolution proposed by the New Jersey Foundation for Health Care Evaluation, which was endorsed by the Board of Trustees, MSNJ, (and so noted in its annual report to the House of Delegates) calls upon "The Medical Society of New Jersey to develop, through the New Jersey Foundation for Health Care Evaluation, and in cooperation with the component societies, a proposal for the establishment of one or more independent physicians' associations and/or a prepaid health care contract."

What are the official views or position of this, the oldest state medical society in the nation, on a subject of such enormous importance to both patient and physician? How has the HMO Act of 1973, with its imminent amendments, affected our thinking? Officially, not at all! We've been much too busy with our own personal economic problems, i.e., professional liability insurance, that euphemism which the public insists on calling "malpractice" insurance. Strangely enough, the threatened economic impact of prepaid health care on an apathetic physician community can be far greater than that impending in the cost of professional liability insurance protection.

It is true that there are doctors throughout the State whose vision and energies have enabled them to investigate this concept of health care delivery, both through the closed and open panel route. There are others who are about to embark upon this experience, providing they are not first strangled by the red tape of organization, or they do not become disenchanted by the discovery

that the planning is all being done by non-physicians, who then will expect the physician to deliver their promises to the subscriber. Such a contretemps is hardly an improvement on his relations with the present third party payer of indemnity insurance. Many a burgeoning prepaid health care plan has been successfully sold to both public bodies on the prospect that sufficient physicians to implement said plans are ready, willing, and able to ensure success! At present, this is an over-statement for the very reasons just detailed — an unhappiness with the third party payer concept! Intuitively, many physicians feel that there is little to be gained by supporting another insurance program, especially one described as "The Doctors' Plan," when their input as to parameters of coverage and claims-review is negligible and their concept of administrative and marketing costs even less. Then, they are asked to risk 10 to 20 percent of their fee, to be held in escrow for one year, to ensure the financial health of the plan. This may be the proverbial straw that broke the camel's back!

Organized Medicine's Responsibility

What then should be the society's position? Should it have one? There are those who believe it should — providing certain concepts concerning organized medicine's responsibility to the public and to itself can be agreed upon. They are as follows:

1. Organized medicine has the responsibility, innate in its very *raison d'être*, to approve or, if need be, invent and implement a system that will ensure basic health care needs (by physician definition) for every citizen, irrespective of economic status.
2. Organized medicine has the further responsibility to ensure its physicians of an approved method of health care delivery in which they can be happy and content — be it solo, group, or closed panel.

*A personal commentary by Richard E. Lang, M.D., a member of the Board of Trustees, MSNJ, a member of the Board of Trustees, NJFHCE, and chairman of its Committee on HMO-IPA (Health Maintenance Organizations and Individual Physicians Associations).

These two concepts can relate successfully to a prepaid health care package. No one would deny the public need for health care insurance. Hospital costs and the costs of physician care are most certainly beyond the average patient's ability to pay out-of-pocket. Indemnity plans have done well by that percentage of the public who can afford to purchase them and Medicare has done every bit as well for those over age 65. Medicaid, on the other hand, has been a disaster — it has promised far more than it could deliver despite a very generous subsidy from the physician in the form of reduced fees. Patients on public assistance rolls have fared no better than they ever did, and, for the most part, they are using the same clinical facilities as of yore.

Since the public feels that health care is an inalienable right — and it is — we should review how to include everyone in any program to be offered to the public. First, let us evaluate the failure of the present system of indemnity coverage. It has failed for only one reason — as presently structured it can't afford to underwrite the entire population for a premium it can afford!

The health insurance industry, both profit and nonprofit, has succeeded in enrolling almost the entire low-risk population in its respective programs; this leaves many on Medicaid and the general assistance rolls to be provided for by the Federal government and the states. That portion of the population constitutes a high-risk group, which prevents both the Federal and State governments from success in meeting their needs. This fact is the primary cause for the hue and cry for National Health Insurance. Unless we have a better plan we had better recognize the need for same.

A Plan

Armed with reasonable courage and marked determination, many believe the blueprint for an all-encompassing plan can be created from existing formulas which have proved successful on a smaller scale, i.e., foundations for health care delivery. Labor and industry should join in a statewide, self-insured HMO, with reinsurance, and should contract with eight IPAs for health care delivery. Claims review would be performed by the eight PSROs, which then will exist. Ex-

perience will permit entry into the system of Medicaid and public assistance rolls on a fiscally sound unit premium, which it is anticipated the State can afford, while ensuring its enrollees equal care with every other enrollee in the system.

Obviously, the most revolutionary aspect of this proposal concerns the self-insurance aspect, which is certainly the sine qua non of the entire proposal. Why?

As presently practiced, the cost of medical care rarely is given much thought by either the physician or patient, both of whom rely on insurance coverage to bear the burden. Inasmuch as physicians are deemed responsible for 85 percent of hospital costs, we bear a high degree of responsibility to be sure that all services ordered are as precisely appropriate to the patients' needs as we can make them. On the other hand, patient demands for services that are not precisely appropriate to his needs must, of necessity, be discouraged! How do we encourage these attitudes on the part of patient and physician? To many the obvious answer is to make them aware of costs through allowing participation in the saving accrued through such joint cooperation. To accomplish this end, without removing the profit from stockholders in the health insurance companies, would not appear to be fiscally possible — hence, the need for self-insurance! Those companies of a non-profit corporate structure fail to answer the need simply because their operation is so structured as to permit insufficient physician and public participation in the area of risk responsibility. The latter is the most formidable educational aid available to ensure a desire for appropriate care (as defined by physicians) by both patient and doctor.

This is not a new concept. It is, in fact, little more than the cooperative movement brought into the area of medical practice. Like any mode of insurance, it can succeed for all the people at both ends of the economic spectrum only if risk is spread as widely as possible between high and low-risk segments of the population. It is the only method in the opinion of some that will guarantee a realistic awareness of the economics of medical practice on the part of both patient

and physician, while giving each an opportunity to ensure meaningful remedies to excesses without the trauma of having the same imposed by either government and/or the financial structure of the insurance industry.

Approximately forty years ago financial arrangements between physicians and patients began to be relinquished by both sides to the third party payer — with almost complete ab-

dication on the part of each. Now, neither patient nor physician has a very clear idea of the financial consideration under which their relationship operates. It would seem that both patient and physician remove this deplorable condition by a more active participation in the organization charged with this duty, namely, a prepaid health care program similar to that outlined above.

Richard E. Lang, M.D.

INFORMATION FOR READERS AND CONTRIBUTORS

The Journal, the official organ of The Medical Society of New Jersey, is published monthly under the direction of the Committee on Publication. *The Journal* is released the first week of the month, and a copy is sent to each member of the Society.

Change of Address: Notice of change of address should be sent promptly to The Medical Society of New Jersey, P.O. Box 904, Trenton, New Jersey 08605.

Communications: Members are invited to submit to *The Journal* any suggestions for the welfare of the Society, as well as comments or criticisms of material in *The Journal*. All such communications should be directed to the Editorial Office of *The Journal*. The Publication Committee reserves the right to publish, reject, edit, or abbreviate all communications submitted.

Contributions: Manuscripts (original and one copy) submitted to *The Journal* must be typewritten, *double-spaced* on letter size (about 8½ x 11 inch) paper, and forwarded to the

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Illustrations: Authors wishing illustrations for their articles will submit glossy prints or original drawings.

Bibliography: Format used in JAMA must be followed. References should be numbered in order of citation in the text.

Reprints: Reprints may be ordered after the author has been notified that his article has been selected for a specific issue of *JMSNJ*.

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

P.O. Box 904, Trenton, New Jersey 08605

NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes

September 19, 1976

A regular meeting of the Board of Trustees was held on Sunday, September 19, 1976, at the Executive Offices, Trenton. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

Professional Liability . . . Approved the following actions: (a) oppose activation of the Reinsurance Facility; (b) negotiate with Chubb for a three-to six-month renewal policy; and (c) create a physician-owned carrier to begin insuring at expiration of the Chubb "short form."

Note: The above actions resulted from a meeting with representatives of Chubb and Son, the Britton Agency, and Mr. Norris of the American Health Systems, at which time the Board was advised that Chubb had reached a corporate decision to reduce its professional liability underwriting and would be meeting with the State Insurance Commissioner on September 22 to discuss activation of the State Reinsurance Facility. It was noted in a briefing by Dr. Todd and Mr. Maressa that such activation would involve not only premium payments by the insureds but also capital contributions.

Representatives of MSNJ met with the Commissioner and Chubb and the following course of action was agreed upon:

(1) MSNJ would form, with the approval of the Insurance Department, a physician-owned and managed insurance company.

(2) Rate filing by Chubb, effective November 1, was supported by documented evidence and would be approved by the Commissioner.

(3) The Commissioner would grant Chubb permission to write a short-term policy, at the expiration of which coverage would be placed in the Society-formed carrier.

(4) Plans and documents will be filed with and subject to approval of the Commissioner. There will be no hiatus in coverage nor any change in premium structure from that previously announced.

Treasurer's Report . . . Approved a report of the Treasurer, including a request for transfer of \$35,430 in budgetary accounts for fiscal 1975-1976 to cover overexpenditure in 14 accounts where appropriations were not sufficient to cover inflated costs.

Denial of Payment for Hospital Admission . . . Voted to refer to the Quadripartite Permanent Committee on Blue Cross/Blue Shield the case in which Blue Cross denied reimbursement for a hospital admission, alleging it was for diagnostic studies and could have been handled on an outpatient basis. The Public Advocate had requested MSNJ's review and action.

Council on Mental Health . . . Approved the report of the September 15 meeting of the Council on Mental Health, including the following recommendations:

1. That MSNJ allot a sum of \$3,000 to hire a technical assistant to the Council on Mental Health to prepare a response to the New Jersey Mental Health Planning Committee's report titled "A Manual for Reform of New Jersey's Mental Health Case System." The Council expressed concern that implementation of the reforms suggested would result in inadequate care of the mentally ill in New Jersey.

2. That MSNJ reaffirm the AMA's position on hypnosis, recognizing it as a valuable adjunct, urging hospital administrators to act for change by recognizing its value, and urging presidents of CMDNJ schools to encourage the teaching of hypnosis as part of their curricula.

Council on Medical Services . . . Approved a report of the September 8 meeting of the Council on Medical Services, including the following recommendation:

That MSNJ again communicate with Commissioner of Health Finley requesting reimbursement for physicians performing utilization review functions regarding cost containment — as set forth in Resolution #16.

Marsh vs. Department of Health . . . Voted to commit the Society to expend up to \$5,000 in legal expenses (following review, as to its soundness, of the Marsh vs. New Jersey Department of Health case re failure to approve a certificate of need application to obtain a CAT scanner for Dr. Marsh's office).

HEW Program Review Teams . . . Referred to the President a request from HEW for nomination of three MSNJ candidates to serve on a Program Review Team being established in New Jersey, stressing that the physicians so nominated be sympathetic to MSNJ's position on PSRO's.

Committee on Medical Education . . . Approved the September 9 report of the Committee on Medical Education, including the recommendation that the Academy of Medicine investigate courses submitted for their approval if fees seem excessive, and report to MSNJ's Committee on Medical Education, who then would seek the sponsoring agency's explanation, if so indicated.

Ad Hoc Committee on Professional Liability . . . Approved the following recommendations from the Ad Hoc Committee on Professional Liability:

1. That MSNJ contract with American Health Systems to prepare for implementation of a captive insurance company or association involving an expenditure of approximately \$50,000.
2. That MSNJ inform the New Jersey Hospital Association of its opposition to the practice of joining unnamed third party defendants in professional liability actions.
3. That MSNJ advise NJHA of its opposition to "sliding scale" covenants between plaintiffs' and defendants' attorneys and request NJHA to adopt a similar stand.

New Jersey Hospital Association . . . Received as informative the following report from Rudolph C. Gering, M.D., MSNJ's liaison representative to the New Jersey Hospital Association:

1. NJHA voted to create a broad educational program for hospital trustees, administrators, and medical staffs, the objective being to stimulate change and improved health care systems.
2. NJHA will convey its concern on the 1976-77 State Medical Facilities Plan which predicates a 90 percent medical/surgical bed utilization and 80 percent occupancy rate for pediatrics and obstetrics/gynecology beds which differs with the present desired levels of 80 and 70 percents respectively, and could in the future force closure of some supposedly under-utilized beds.
3. Expressed concern over inequities in payments to hospitals by Medicaid occasioned by reduced rates and underpayments.
4. Noted that John F. Kennedy Hospital in Edison, upon being informed that their premium for liability insurance for 1976 would increase to \$650,000, developed its own insurance program which would require a reserve of \$600,000 in calculating rates. Commissioner Finley denied the hospital's \$600,000 reserve, but would have allowed an insurance premium of \$650,000 as a hospital expense.

Temporary Certification . . . Directed that the Executive Committee request the State Board of Medical Examiners to participate in a joint meeting to discuss further temporary certification or licensure.

Establishment of a Medical School in South Jersey . . . Directed that Drs. Solomon be informed that MSNJ continues to support establishment of a medical school in South Jersey.

Note: The above action resulted from further review of allegations by Drs. Marvin and Jeffrey Solomon that creation of a medical school in South Jersey would be contrary to advice of the Medical Task Force, RMS, and the basic science faculty in Newark.

Exemption from Professional Liability Assessment . . . Considered a request from the Occupational Medical Association of New Jersey that members of its organization be exempted from the assessment because they have no financial interest in its purpose, and voted to inform the association of MSNJ's policy that all members, not dues-exempt by virtue of county action, are expected to pay, since it is a matter of vital importance to all physicians.

Special Professional Liability Assessment for New Members . . . Reviewed a communication from Essex County protesting the \$200 mandatory assessment on all new members.

. . . Agreed to grant an exemption from dues and the assessment to new members until such time as any financial hardship is resolved. An informational memorandum to that effect will be made available to all county societies.

Formation of Intern and Resident Committees . . . Directed that AMA guidelines on forming intern and resident committees at the local hospital level be supplied to Union County Medical Society. (This action was prompted by the inquiry to MSNJ for a specific plan.)

A-New Jersey Influenza Vaccine . . . Directed that a communication be sent to the Commissioner of Health (with copies to the Governor, New Jersey newspapers, and component societies) voicing MSNJ's concerns regarding the swine flu immunization program, and offering cooperation to ensure a successful program.

Exemptions . . . Noted that the State Board of Medical Examiners, at the July 14 meeting, formally ruled that all exemptions of licensure currently in effect or granted up to December 30, 1977 for physicians practicing in state and county institutions will be terminated on December 31, 1977.

OWNERSHIP STATEMENT

STATEMENT OF OWNERSHIP, MANAGEMENT
AND CIRCULATION

(Required by 39 U.S.C. 3685)

1. Title of Publication: THE JOURNAL OF THE MEDICAL
SOCIETY OF NEW JERSEY.

2. Date of Filing: September 28, 1976.

3. Frequency of Issue: Monthly.

3-A. No. of Issues Published Annually: 12.

3-B. Annual Subscription Price: \$10.

4. Location of Known Office of Publication: 315 West State
Street, Trenton, New Jersey 08618.

5. Location of the Headquarters or General Business Offices of
the Publishers: 315 West State Street, Trenton, New Jersey 08618.

6. Names and addresses of publisher, editor and managing
editor: Publisher, The Medical Society of New Jersey, 315 West
State St., Trenton, New Jersey 08618. Editor, Arthur Krosnick,
M.D., 315 West State St., Trenton, New Jersey 08618. Asst. Editor,
Mrs. Marjorie Treptow, 315 West State St., Trenton, New Jersey
08618.

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Society of New Jersey, 315 West State St., Trenton, New Jersey
08618 (a non-profit corporation of New Jersey).

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owning or holding 1 percent or more of total amount of bonds,
mortgages or other securities: none (a non-profit corporation of
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9. For completion by non-profit organization authorized to mail
at special rates (Section 132.122, PSM). The purpose, function,
and nonprofit status of this organization and the exempt status for
Federal income tax purposes have not changed during preceding
12 months.

10. Extent and nature of circulation:	Average no. copies each issue during preceding 12 months	Actual number of copies of single issue published nearest to filing date
A. Total No. copies printed (Net Press Run)	9,941	9,885
B. Paid Circulation		
1. Sales through dealers and carriers, street vendors and counter sales	—	—
2. Mail subscriptions	9,393	9,274
C. Total Paid Circulation	9,393	9,274
D. Free Distribution by mail carrier or other means — samples, complimentary, and other free copies	382	392
E. Total Distribution (Sum of C and D)	9,775	9,666
F. Copies Not Distributed		
1. Office use, left-over, unaccounted, spoiled after printing	166	219
2. Returns from news agents	—	—
G. Total (Sum of E & F—should equal net press run shown in A)	9,941	9,885

11. I certify that the statements made by me above are correct
and complete. (Signed)

Robert H. Lombert,
Business and Financial Manager, MSNJ

12. For completion by publishers mailing at the regular rates
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provides in pertinent part: "No person who would have been en-
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mail such matter at the rates provided under this subsection unless
he files annually with the Postal Service a written request for per-
mission to mail matter at such rates." In accordance with the
provisions of this statute, I hereby request permission to mail the
publication named in Item 1 of the phased postal rates presently
authorized by 39 U. S. C. 3626. (Signed) Robert H. Lombert,
Business and Financial Manager, MSNJ

Professional Liability

"Going Bare"

There is increasing reference in periodicals and
on television regarding individual physicians
who have opted to discontinue their professional
liability insurance — "Going Bare" so to speak.
Such presentations must be evaluated quite
carefully as it appears there is a tendency to in-
tegrate information regarding those who have
actually discontinued their coverage with infor-
mation for physicians who are *merely con-
sidering* such action.

It appears the number of physicians in New
Jersey who have taken such action to date is
minuscule. From information provided through
various sources, it is the physicians in high-risk
areas and, accordingly, in states whose
professional liability premiums are among the
highest, who appear to be the most prone to dis-
continue their insurance despite the continuing
increase in the numbers of claims being made.
As premiums continue to increase, physicians in
other areas also may consider this method of
"combating the present system" which may
appear to be doing nothing more than digging
deeper and deeper into a physician's income.

In view of the fact that "going bare" is a
relatively new phenomenon, there are little hard
data available relative to the pros and cons in-
volved in this concept. However, for the benefit
of those who may wish to know more about the
approach, the following is a review of alleged
benefits and potential problems as indicated in
various periodicals and from other sources. We
also have included input from defense attorneys
who participate in The Medical Society of New
Jersey program. Please recognize that some of
the conditions indicated in the following may
apply only to New Jersey.

1. *One purported benefit of "going bare" is that
a patient will refrain from commencing an ac-
tion against an uninsured physician.* There seem
to be several trains of thought on this concept.
Some physicians widely publicize that they have

*This item has been prepared by Joseph A. Matt, CPCU, of
the Joseph A. Britton Agency, in accordance with a request
from the Special Session of the House of Delegates
(12/14/75) — see *JMSNJ* 73:166 (February) 1976.

no professional liability insurance hoping that any possible action will be discouraged by this front, or at least be resolved directly with the patient. It appears some doctors take this approach on the theory that the patient will realize "you can't get blood out of a turnip." Any loss of patients as a result thereof is accepted as involving only those who might have been problems anyway. Conversely there is also the physician who conceals the fact that his insurance has been discontinued with full acceptance that any issue which arises will be his own responsibility to handle to whatever degree it becomes necessary.

While a patient's knowledge that a physician is uninsured may preclude the bringing of an action if a relatively minor injury is involved, even this theory is open to question. Certainly in the event of a severe injury, extensive disability or death, it is highly doubtful that a patient's attorney will withhold action because there is no insurance. Physicians are considered to be financially well-off and it is anticipated that seizure of their assets should provide adequate funds to cover most damage awards. Even if such assets are transferred to others in advance of a suit, those accumulated after commencement of the suit, plus future unearned income, might well be made available through court action including garnishment, and relief through bankruptcy action (an undesirable event at best) may or may not be available.

It is the experience of defense counsel assigned to the Medical Society program, that a professional liability claim or suit is pressed most vigorously against the physician(s) who appears to be liable for the alleged malpractice without regard to the question of insurance. It is important to recognize that the insurance carrier for an insured physician, or other health care facility, will not hesitate to involve a physician who is not insured if the carrier believes he is primarily responsible or contributed to the injury, including commencement of a separate action to recoup any payment the carrier may have to make on behalf of their insured.

2. *Some physicians are considering distribution of their assets in advance of any claim or suit to prevent seizure for providing of funds for payment of damages.* Transference of assets for the

sole purpose of preventing seizure may still result in their being taken over regardless of who holds them because of the *intent* behind such action. Even assuming this purpose cannot be proved, taking such action still presents problems. The need to effect such transfers is almost continuous as new assets are accumulated. Such distribution would undoubtedly have to be on a permanent basis and would involve payment of expenses for transfer plus assumption of payment for those taxes or penalties that would result from their disposition. Finally, this procedure could represent a risk if relationships deteriorate with those to whom the transfer is made. In no way does this solve disposition of assets accumulated *after a suit is commenced*, which could accumulate to a sizeable amount.

There is a tendency to overlook the continuing actions by our judiciary system in its interpretation of present statutes so that the ability to initiate a claim or suit or the basis for determining liability is becoming increasingly easier. A case in point is the current interpretation of our "Statute of Limitations." In the view of some, there is almost no limitation on the time that a patient can commence an action regardless of the date on which treatment allegedly causing the injury was rendered. This can mean that an uninsured physician may have to risk his or her assets to defend a suit *many, many* years later, when he may be in a declining income period or reliant on funds that had been set aside for retirement.

3. *Does the lack of insurance affect relationships with other health care providers?*

No clear data on this statement are available at present. One can anticipate that some fellow physicians may become hesitant to accept referrals from, or make referrals to, or participate in providing coordinated medical services with, physicians who are uninsured assuming that there is a greater, or at least unknown, risk involved.

It has been reported that hospitals in New Jersey are evidencing increasing interest in the adequacy and maintenance of professional liability coverage for staff physicians, with some indications that privileges may be withheld if coverage is considered to be inadequate or non-

existent. If this is true, it may *not* be legally enforceable in the final analysis, but is indicative of another type of problem that can develop.

4. *What problems can arise in arranging for defense of a claim or suit by an uninsured physician?* The uninsured physician would want to retain his own counsel who would conduct an investigation and defense on his behalf. Legal costs involved are substantial, frequently involving \$5,000 or more, *not* including expenses normally assumed by an insurance company in making an investigation. You may be interested to learn that one uninsured New Jersey physician has already paid expenses totaling more than three times the premium saved during the seven years he did not carry insurance — and the matter is still pending. Physicians who have chosen to “go bare” admit that this is of substantial concern and have promoted creation of “legal expense insurance” or other methods of funding this obligation — none of which will be without some expense to them even if it becomes available at a later date. One must also question whether the most competent attorney would be available to present a proper defense. Qualified defense counsel in this area is not readily available and the most competent may be committed previously to other interests involved in the same action.

One benefit for New Jersey physicians insured under the Medical Society program is sometimes unrecognized. We refer to the availability of review of claims and suits by County Medical Review and Advisory Committees. These committees have proved extremely valuable to the insured physician, defense counsel, and the insurance companies who previously provided or currently provide insurance to New Jersey doctors. This service would *not* be made available to an uninsured physician.

5. *Is there any change in the psychological factors which normally emerge when a professional liability action is made against an uninsured physician?* Defense attorneys feel they cannot overstress this factor. Commencement of an action, in itself, alleges negligence or incompetence and is traumatic. The uninsured physician's problem is worse because he now is adding the

peril to his own finances as well. Many years may pass before final disposition and the uninsured physician must be completely involved in all activities and decisions over the entire length of time during which the matter is pending. Finally, attitudes and beliefs may prevent his or her taking a completely unbiased approach and thereby failing to effect the settlement of a non-defensible suit at the most propitious time.

There are undoubtedly other proposed benefits or deficiencies not included in the above material. Hopefully this information will enable all physicians better to evaluate the effects of “going bare.” Such action, once taken, is *irreversible* for claims or suits emanating during the period that the physician remains uninsured. The potential for a catastrophic loss will exist through his or her lifetime.

CMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President, CMDNJ

A unique, new, obligatory clerkship in the practice of medicine at the CMDNJ-New Jersey Medical School, Newark, is being offered this year to all members of the senior class.

Organized by Edward A. Wolfson, M.D., M.P.H., director of the Office of Primary Health Care Education, the clerkship will last for a month and will immerse our seniors in the human side of health care — ethical, social, political, economic, legal, and environmental factors that impact on the fight against disease. It is to be expanded to two months next year.

The program is divided into Days of Education and Days of Practice. The former consists of a day a week devoted to case studies, seminars, and group discussions. The latter will comprise at least three days a week, including nights, weekends, and emergencies, in the company of a primary-care physician in a practice setting (office, house calls, and hospital rounds). About 100 primary-care physicians — family practitioners, general internists, general pediatricians and general obstetricians/gynecologists — have joined the clerkship faculty.

It will interest New Jersey physicians to know that the Days of Education portion, four successive Mondays, has been approved for AMA Category 1 continuing education credit. Thus, the practicing physician and the student may, innovatively, learn together. The monthly faculty teams are truly distinctive. The November team, for example, will include Lowell Bellin, M.D., New York City's commissioner of health; John H. Bryant, M.D., dean of the School of Public Health, Columbia University's College of Physicians and Surgeons, and Professor Anne R. Somers, an internationally recognized spokeswoman for consumer health education, on the CMDNJ-Rutgers Medical School faculty.

The October team included Craig D. Burrell, M.D., vice president-external affairs, Sandoz Pharmaceuticals; John G. Freymann, M.D., president, National Fund for Medical Education; Lewis A. Miller, editor-in-chief, *Patient Care* magazine, and Earl Ubell, producer, special broadcasts, NBC News.

What are they discussing? The ethical-legal issues of the practice of medicine; the changing health care-delivery system, including methods of financing and the ability or inability of certain groups to secure care; the changing physician, including the trend toward specialization and the rising costs of health care; the role of other members of the health-care team, such as midwives, nurse clinicians, and physician assistants; medical care quality assurance and evaluation; life style and expectations of patients, consumerism and health education, and physician-patient relationships.

The clerkship, over-all, is devoted to the "care" part of medicine, which we are again coming to realize underlies anything we do to "cure." Cur-

ing may be intermittent, but today's physician must never stop caring, an art that has sometimes been overshadowed and too often lost in the concentration on scientific development and specialization.

From their preceptors and from the faculty teams at the seminars and group discussions, our students will learn something about the human side of medicine, that physicians do not practice in isolation from the society around them, and that their actions as physicians are influenced by external factors, such as the cost of care, manpower distribution, and governmental considerations.

The students will become aware of the role of physicians as patient advocates. They will learn of peer review and the need for accountability and quality control. They will be able to recognize the importance of and necessity for significant participation and responsibility of patients in their own health care, and to determine factors involved in enhancing patient compliance and in modifying patient behavior.

In their clinical program, students may assist their preceptors, but may not engage in any activity that may be construed as the actual practice of medicine. Prominent in each preceptor's office is a sign, reinforced by an open letter to patients, announcing that a "training program for senior medical students" is under way and explaining: "Meeting, interviewing, and examining patients are vital parts of this program . . . We ask your cooperation. If you do not wish a student present during your office visit, please notify the nurse."

Physicians interested in participating as faculty members should contact Dr. Wolfson at CMDNJ-New Jersey Medical School, 100 Bergen Street, Newark 07103.

Auxiliary's 50th Annivesary
The Medical Society of New Jersey Auxiliary
will celebrate its 50th anniversary during
MSNJ's 1977 Annual Meeting in Atlantic City
May 14-17 — Haddon Hall

The Privacy Act and Social Security Disability

(The following message to New Jersey physicians was prepared by the Division of Disability Determinations of the Department of Labor and Industry.)

The Privacy Act of 1974 became effective on September 27, 1975. Since physicians in New Jersey supply vital information to the Social Security Administration to determine eligibility for disability and/or supplemental security income (formerly Department of Public Welfare assistance), it would help the physician to understand how the Act applies to social security disability cases.

In general, the Privacy Act reaffirms the confidentiality of social security records, while instituting changes related to an individual's right to all records about him including medical records and the right to request correction or amendments of the record. The amendment may take the form of corrections of inaccurate information, removal of items of information which are no longer relevant or timely, or the addition of information to supplement incomplete information. To date, requests for corrections or amendments have been infrequent.

In view of the confidential nature of such information, the request and authorization must be in writing, signed, and dated by the individual.

Upon request for disclosure of medical information, the individual will be asked to designate in writing a representative through whom medical records may be disclosed. Such a representative should be willing to receive medical information and to discuss it with the individual.

It is anticipated that in practically all cases, this individual will be the applicant's private physician. However a non-medical representative may be designated. The medical records will be reviewed by an official in the employ of the Social Security Administration to determine that direct disclosure of this information will not be likely to have an adverse effect upon the individual. If the reviewing official should determine that direct disclosure of the medical information would be likely to have an adverse effect on an individual, or it cannot be determined by

reviewing the records that direct disclosure may have an adverse effect, the medical information will be sent to the designated representative rather than the individual.

The number of requests from individuals to inspect medical reports obtained in connection with their disability claim is relatively small. In a great majority of requests the individual already will be aware of much of the information in his medical record.

Another change regards confidential or restricted information. No pledge of confidentiality may be given to the third party, including medical sources providing information to the Social Security Administration about the individual, except in investigative and possible fraud situations. Therefore, medical information should not be forwarded to the Social Security Administration with restrictions or "confidential" annotations.

The new disclosure of information provisions do not change the way physicians should complete medical reports in connection with the patient's disability claim. As always, the emphasis is on the type of objective reporting — that is, symptoms, signs, and laboratory findings relating to the patient's condition that is required for impartial disability determination under both programs. It is important to include pertinent negative findings as well as positive findings in the report. If certain laboratory proceedings or x-rays are deemed advisable but are not available a statement of this fact would be helpful regarding further evaluation.

The medical report should be sufficiently complete so that medical consultants can draw a firm conclusion from the positive findings to determine whether the individual meets the requirements for disability as set forth in the Social Security Act. Although the treating physician may not always agree with the decision, it must be realized that requirements are set by law and all the Social Security Administration can do is follow the law as passed by Congress. Since the decision of disability is based on objective medical evidence only, and not opinion, the physician should refrain from stating opinion in the report. The reporting physician should keep in mind that not only are

opinions not a basis for determinations, but, should the individual request a copy of medical evidence used to prepare the decision in a case, the opinion included in the report will be part of the information released.

In this brief article, we have discussed the major changes in the Social Security Disability Program brought about by the Privacy Act and restated the importance of prompt, complete medical reports cannot be overemphasized. With prompt, complete medical reports initially, the necessity of recontacting the physician and utilizing his or her valuable time obtaining additional information can be eliminated. Although completing these reports does place additional demands on a busy physician's time, the treating physician's continued cooperation aids in promoting prompt and hopefully fair claims.

Therapeutic Drug Information Center*

The Schwartz Inter-National Pharmaceutic and Therapeutic Drug Information Center of the Brooklyn College of Pharmacy, Long Island University, compiles the information contained in this column each month. The Center serves as a source of intelligence on therapeutic and pharmaceutical information not readily available to physicians, at no charge to them, and provides this information with minimal time involvement. It is staffed by trained pharmacists; Jack M. Rosenberg, Pharm. D., Associated Professor and Chairman, Division of Clinical Pharmacy, Brooklyn College of Pharmacy, is Director and Walter Modell, M.D., Emeritus Professor of Pharmacology at Cornell University Medical College, is pharmacologist consultant. The service is available Monday through Friday from 9 a.m. to 4:30 p.m. — telephone (212) 622-8989 or 636-7535. The following are questions and answers handled by the Center recently.

1. Please provide information concerning the systemic side effects of topical corticosteroids.

Topical corticosteroids hold an unrivaled position among medications used for the treatment of skin disorders. They are extensively used with little fear of producing side effects associated with systemic corticosteroid therapy.

The local adverse effects of these topical agents are well documented and include aggravation of existing local infections, impediment of healing, acneform eruptions, and epidermal or dermal atrophy.^{1,2} Topical corticosteroids may also be procarcinogenic in skin cancer due to suppression of immunological defense mechanisms of the epidermis.³

Regarding the systemic effects of topical corticosteroids, the official literature for these preparations warns that their use, particularly under occlusion, may produce adrenal suppression and other systemic corticosteroid effects. Two most important factors believed to influence systemic absorption of topical corticosteroids are the amount of drug applied (the surface area and period of time of application) and condition of the skin.

It has been demonstrated that fludrocortisone acetate (Florinef®) lotion or ointment when applied to the skin produced a decrease in urinary sodium excretion suggesting a systemic mineralocorticoid effect.⁴ Scoggins and Kliman⁵ tested several corticosteroid creams and observed that under occlusion there were systemic side effects suggesting suppression of pituitary adrenal function. They further observed that without an occlusive dressing significant amounts of the drug were absorbed only when the applied dose was very large.

Kelly, *et al.*⁶ described a case of iatrogenic Cushing syndrome in a 42-year-old woman who applied topically 18 mg of betamethasone 17-valerate (Valisone®) daily for two years (140 gms of cream containing one part of 0.1 percent betamethasone 17-valerate cream and eight parts of bland cream). More recently, May, *et al.*⁷ observed another case of Cushing Syndrome in a patient who was using 38 mg (approximately 38 gm of 0.1 percent cream) of triamcinolone acetonide (Kenalog®, Aristocort®) per day for several years. This amount was applied to the total body surface and covered with an occlusive dressing. The patient developed clinical adrenal insufficiency after discontinuation of the steroid cream necessitating systemic hydrocortisone therapy.

Pascher,⁸ in a review article on systemic reactions to topically applied drugs, mentioned experiences with seven patients who exhibited systemic adverse effects attributed to the use of topical corticosteroids. The patients used these preparations from 10 days to 30 months. Two infants and a 5-year old boy were treated with unoccluded hydrocortisone. The other four patients were exposed to fluorinated preparations with and without occlusion. The adverse reactions mentioned for the patients were grouped together and included Cushingoid features or syndrome in three, arrested growth or failure to thrive in three, and pseudotumor cerebri (a known complication of systemic corticosteroid withdrawal) in one patient who received unoccluded hydrocortisone for 30 months.

In conclusion, in addition to the local side effects associated with topical corticosteroids, it is apparent that topical corticosteroids are percutaneously absorbed and have the potential for producing serious systemic effects.

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¹Purdy MJ: Adverse effects of strong topical corticosteroids. *Drugs* 8:70-77 1974.

*This month's column was prepared by J. M. Rosenberg, Pharm. D., P. Sangkachand, B.S., M.K. Raina, M. Pharm., Ph.D., and W. A. Simon, Pharm. D., Brooklyn College of Pharmacy, LIU.

²Kligman AM ; Leyden JJ: Adverse effects of fluorinated steroids applied to the face. *JAMA* 229:60-62 (July) 1974.

³Deakin MJ: Current dangers and problems in the topical use of steroids. *Med J Aust* 1:120-121 (Jan 31) 1976.

⁴Fitzpatrick TB, *et al*: Sodium retention and edema from percutaneous absorption of fludrocortisone acetate. *JAMA* 158:1149-1152 (July 30) 1955.

⁵Scoggins RB; Kliman B: Percutaneous absorption of corticosteroids. *N Engl J Med*. 273:831-840 (Oct 14) 1965.

⁶Kelly A, *et al*: Iatrogenic Cushing's syndrome. *Br Med J* 46:114 (Oct) 1972.

⁷May P, *et al*: Cushing syndrome from percutaneous absorption of triamcinolone cream. *Arch Intern Med* 136:612-613 (May) 1976.

⁸Pascher F: Systemic reactions to topically applied drugs. *Drug Ther* 6:125-130 (June) 1976.

2. Does doxepin possess greater anti-anxiety effects than other tricyclic antidepressants?

Doxepin (Sinequan[®], Adapin[®]) is a tricyclic antidepressant structurally related to amitriptyline (Elavil[®]). Unlike other tricyclic antidepressants, doxepin is recommended for the treatment of depression and/or anxiety. Thus it is recommended as a tranquilizer or antidepressant or both. (Other drugs in this class such as amitriptyline also have mild tranquilizing properties but are not recommended as tranquilizers in their package inserts.)

The anti-anxiety effects of doxepin have been compared with anti-anxiety agents such as chlordiazepoxide (Librium[®]) and diazepam (Valium[®]) with variable results.^{1,2,3} Our search did not reveal any study directly comparing anti-anxiety effects of doxepin with other tricyclic antidepressants.

Prange,⁴ in a review article on the use of drugs in depression, rated doxepin, nortriptyline (Aventyl[®]) and amitriptyline as having the most anti-anxiety effects among the tricyclic antidepressants, and imipramine (Tofranil[®]), desipramine (Pertofrane[®]), and protriptyline (Vivactil[®]) as having intermediate anti-anxiety effects.

Grof, *et al*.⁵ compared doxepin with amitriptyline in 22 patients in a double-blind trial over a period of four weeks. They found both drugs to be equal in their overall antidepressant activity but found doxepin particularly beneficial for the symptoms of anxiety.

In a double-blind study over a period of six weeks, Sanger⁶ utilized doxepin or amitriptyline in the treatment of anxiety and depression displayed in allergy patients whose allergy symptoms did not respond to conventional treatment. The author suggested that doxepin was more effective than amitriptyline in the treatment of anxious and depressed patients with dermatologic allergy.

In a study by Kiev⁷ of 89 patients attending a suicide prevention clinic, data indicated a trend favoring doxepin to amitriptyline with regard to percentage of patients showing improvement. The author attributed this difference to doxepin's superior anti-anxiety activity.

Solis, *et al*.⁸ evaluated the clinical effectiveness of doxepin and amitriptyline in 34 depressed patients. The authors observed that doxepin had greater antidepressant activity than amitriptyline and exhibited anxiolytic effects.

Goldstein and Pinosky⁹ compared the efficacy of doxepin to that of the combination of perphenazine/amitriptyline (Triavil[®]) in the treatment of psychoneurotic outpatients displaying mixed anxiety depressive reactions. Patients were randomly given either the combination of perphenazine/amitriptyline (15 patients) or doxepin (11 patients) in a double blind fashion for at least four weeks. Adjustments were made in dosage based on each patient's clinical response. At the end of the four week period, both forms of treatment were equally effective; however, the pattern of improvement differed. The doxepin-treated patients improved within the first seven days of treatment and those in the other group responded between the seventh and fourteenth day of therapy.

In conclusion, doxepin has anti-anxiety effects. Evidence clearly demonstrating its superiority to other tricyclic antidepressants such as amitriptyline in relieving anxiety, although implied in several studies, could not be conclusively demonstrated from our search.

References

¹Osol A; Pratt R: *The United States Dispensatory*, 27th Edition, Philadelphia, Lippincott, 1973, p. 457.

²Kingstone E, *et al*: Doxepin versus chlordiazepoxide: A double-blind study on anxious outpatients, *Curr Thera Res* 12:213-222 (Apr) 1970.

³Jones BL, *et al*: A comparison of doxepin with diazepam and amitriptyline in general practice. *N Z Med J* 76:174-179 (Sept) 1972.

⁴Prange AJ: The use of drugs in depression: Its theoretical and practical basis. *Psychiatr Ann* 2:56-73 (Feb) 1973.

⁵Grof P, *et al*: Doxepin versus amitriptyline in depression: A sequential double-blind study. *Curr Thera Res* 16:470-476 (May) 1974.

⁶Sanger MD: The treatment of anxiety and depression in the allergic patient. *Ann Allergy* 27:506-510 (Oct) 1969.

⁷Kiev A: The role of chemotherapy in managing potentially suicidal patients. *Dis Nerv Syst* 35:108-111 (Mar) 1974.

⁸Solis H, *et al*: Clinical evaluation of doxepin and amitriptyline in depressed patients. *Curr Thera Res* 12:524-527 (Aug) 1970.

⁹Goldstein BJ; Pinosky DG: Clinical evaluation of doxepin in anxious depressed outpatients. *Curr Thera Res* 11:169-177 (Apr) 1969.

3. Please provide me with information concerning nefopam (Acupan[®]).

Nefopam is a potent non-narcotic analgesic drug in an advanced stage of investigation by Riker Laboratories. It is an analog of the muscle relaxant orphenadrine and thus chemically and pharmacologically unrelated to any presently marketed analgesics. The drug is active orally as well as

parenterally. Unlike morphine, nefopam appears not to produce marked central nervous system or respiratory depression.

Sunshine and Laska¹ conducted a double-blind clinical trial to compare the effectiveness of nefopam (10 and 20 mg) and morphine (6 and 12 mg) in 74 patients who required parenteral analgesia for moderate to severe postoperative and somatic pain. The authors found that single administration of 20 mg of nefopam HCl produced approximately the same analgesia as 12 mg of morphine sulfate.

In a double-blind cross-over study involving 20 patients, nefopam (20 mg I.M.) was found to be as effective as 50 mg I.M. meperidine for the relief of pain associated with intervertebral disc disease and carcinomatous bony metastasis.²

In a study involving 60 patients with moderate to severe pain associated with musculo-skeletal disorders, either nefopam (60 mg) or aspirin (600 mg) were administered orally three times a day for three days. The results based on the patients' records showed that there was high initial pain relief with nefopam; however, at the end of three days no statistically significant differences were apparent in two treatment groups. Nausea was the most common side effect noted with nefopam, and there was no evidence of gastrointestinal bleeding.³ Workmon and Winter⁴ in a randomized double-blind study also compared orally administered nefopam with aspirin and found that nefopam had a faster onset of action.

A study to compare the respiratory effects of nefopam to morphine in healthy male volunteers was reported by Gasser and Bellville⁵. The medications, which consisted of 20 and 40 mg nefopam, 5 and 10 mg morphine, and saline solution as placebo, were administered intramuscularly. The authors found that there was a significant difference between the mean respiratory depressant effects of nefopam and morphine, the latter producing more effect than the former. Both drugs had significantly more respiratory depressant effects than the placebo.

A double-blind 12-week study was performed by Klotz⁶ to determine the long-term safety of nefopam. A placebo or nefopam 60 mg was administered orally three times daily. The author found that nefopam was very well tolerated and there was no evidence of habituation or dependency as judged by the investigators and/or reported by the subjects.

From our search of the literature, it appears that nefopam administered orally or parenterally possesses potent analgesic activity. To date it has not been implicated in producing gastrointestinal bleeding, habituation or abuse tendency, or clinically significant respiratory depression.

References

¹Sunshine A, Laska E: Nefopam and morphine in man. *Clin Pharmacol Ther* 18:530-534 (Nov) 1975.

²Gassel MM *et al*: Controlled clinical trial of oral and parenteral nefopam hydrochloride. A novel and potent analgesic drug. *J Clin Pharmacol* 16:34-42 (Jan) 1976.

³Kolodny AL; Winter Jr L: Further clinical evaluations of nefopam hydrochloride: A new analgesic. *Curr Thera Res* 17:519-524 (June) 1975.

⁴Workmon FC; Winter Jr L: A clinical evaluation of nefopam hydrochloride (Acupan®): A new analgesic. *Curr Thera Res* 16:609-616 (June) 1974.

⁵Gasser JC; Bellville JW: Respiratory effects of nefopam. *Clin Pharmacol Thera* 18:175-179 (Aug) 1975.

⁶Klotz AL: Long-term safety of nefopam hydrochloride (Acupan®): A new analgesic formulation. *Curr Thera Res* 16:602-608 (June) 1974.

211th Annual Meeting Haddon Hall — Atlantic City May 13-17

Friday

3:30 p.m. — Board of Trustees Meeting

Saturday

8:00 a.m. — Registration Opens

9:00 a.m. — Governor's Conference "Government and Medicine"

12:00 p.m. — Exhibits Open

12:00 p.m. — Golden Merit Award Ceremony and Reception

2:00 p.m. — Motion Picture Theatre

4:00 p.m. — House of Delegates

5:00 p.m. — Reference Committees (4)

7:30 p.m. — Cocktails, Dinner, Entertainment, Music, and Dancing — Cozy Morley Wing-ding and Bash

Sunday

8:00 a.m. — Registration Opens

8:30 a.m. — AMA Issues Workshop

9:00 a.m. — Exhibits Open

9:00 a.m. — Scientific Sessions

10:00 a.m. — Reference Committees (5)

10:00 a.m. — Motion Picture Theatre

12:00 p.m. — Luncheons

1:00 p.m. — Scientific Sessions

3:00 p.m. — House of Delegates (election)

4:30 p.m. — Widows and Orphans Meeting

6:30 p.m. — Inaugural Reception

8:00 p.m. — Inaugural Dinner Honoring President-Elect Begen

Monday

7:30 a.m. — JEMPAC Breakfast

8:30 a.m. — Registration Opens

9:00 a.m. — Exhibits Open

9:00 a.m. — Scientific Sessions

10:00 a.m. — Motion Picture Theatre

12:00 p.m. — Luncheons

1:00 p.m. — Scientific Sessions

2:00 p.m. — Motion Picture Theatre

3:00 p.m. — House of Delegates

3:30 p.m. — Exhibits Close

5:30 p.m. — JEMPAC Wine and Cheese Reception

8:00 p.m. — Annual Dinner-Dance (Entertainment)

Tuesday

9:00 a.m. — Registration Opens

9:00 a.m. — House of Delegates

12:00 p.m. — Registration Closes

3:00 p.m. — Board of Trustees

PHYSICIANS SEEKING LOCATION IN NEW JERSEY

The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

CARDIOLOGY — William S. Sarnat, M.D., 711 Keswick Drive, Iowa City, Iowa 52240. Wayne State 1970. Board certified (IM). Group or hospital-based, teaching post. Available August 1977.

ENDOCRINOLOGY — Daniel L. Lorber, M.D., 119-29th Avenue, South, Nashville, Tennessee 37212. Albert Einstein 1972. Board certified. Group or hospital-based. Available July 1977.

FAMILY PRACTICE — Harry Collins, M.D., 380 Maple Avenue West, Vienna, Virginia 22180. Hahnemann 1974. Board eligible. Group or ER in southern New Jersey. Available.

Jonathan B. Tocks, M.D., 1315 Strafford Road, Camp Hill, Pa. 17011. Michigan 1973. Group. Available July 1977.

Gary M. Cummins, M.D., 124 Oak Ridge Drive, York, Pa. 17400. Pittsburgh 1974. Board eligible. Available July 1977.

S. Osman, M.D., 10460 Curotte Avenue, Montreal, P.Q., Canada H2C 2Y7. Cairo 1968. Group or full-time emergency. Available.

GASTROENTEROLOGY — Robert D. Fusco, M.D., 1416 Wyldewood Road, Durham, North Carolina 27704. University of Pittsburgh 1973. Board eligible. Group or partnership. Available July 1977.

Tarig Butt, M.D., 33 Highland Street, Apt. 3-H, New Britain, Connecticut 06052. King Edward, Lahore (Pakistan) 1971. Board certified. Group, partnership, or solo. Available July 1977.

HEMATOLOGY/ONCOLOGY — C. U. Zachariah, M.D., 174-10 84th Avenue, Apt. 4G, Jamaica, New York 11432. Madras (India) 1970. Board eligible. Group, solo, or hospital-based. Available July 1977.

INTERNAL MEDICINE — Stephen Winograd, M.D., 208 Walnut Street, Montclair 07042. NYU 1972. Subspecialty, gastroenterology. Board certified. Solo, partnership, group. Available July 1, 1977.

Jeffrey I. Selwyn, M.D., 711 Pampa Place, Tucson, Arizona 85704. SUNY, Downstate 1972. Board certified. Group or partnership. Available January 1977.

Gene H. Ginsberg, M.D., 1735A Clarion Loop, Cannon

AFB, Clovis, New Mexico 88101. Jefferson 1972. Board certified. Group, partnership or association, solo. Available July 1977.

Elihu J. Goren, M.D., 5509 Greentree Road, Bethesda, Maryland 20034. Einstein 1973. Subspecialty, endocrinology. Board eligible. Group or partnership. Available July 1977.

Fred H. Hyer, M.D., 6640 SW Fifth St., Pembroke Pines, Fla. 33023. CMDNJ 1970. Subspecialty, rheumatology. Board eligible. Group, partnership, or solo. Available July 1977.

Joseph L. Verdirame, M.D., 200 Carman Ave., Apt. 6-G, East Meadow, New York 11554. Virginia 1974. Group. Available July 1977.

John S. Zesk, M.D., 56 Castleman Rd., Rochester, New York 14620. Rochester 1970. Subspecialty, cardiology. Board certified (IM). Group, clinic or partnership. Available July 1977.

Sudarshan K. Singal, M.D., 3737 Beaubien Street, Apt. 909, Detroit, Michigan 48201. Amritsar (India) 1969. Subspecialty, gastroenterology. Board certified. Any type practice. Available July 1977.

Mohammed Ashraf Sufi, M.D., 9587 Pickwick Circle East, Taylor, Michigan 48180. Dow, Karachi (Pakistan). Subspecialty, gastroenterology. Group, partnership, academic career. Available July 1977.

Donald Durham Volkmer, M.D., 24 Stoneland Road, Shrewsbury, Massachusetts 01545. Northwestern 1972. Board eligible. Partnership, small group. Available July 1977.

Leonard D. Ehrlich, M.D., 2200 Columbia Pike, Arlington, Virginia 22204. George Washington University. Subspecialty, gastroenterology. Board certified. Group or partnership. Available August 1977.

Geeta Mukhopadhyay Das, M.D., 140 North Broadway, Apt. L-4, Irvington, New York 10533. Royal College (England) 1972. Board eligible. Part-time group or hospital-based. Available.

Ashoke Kumar Das, M.D., 140 North Broadway, Apt. L-4, Irvington, New York 10533. Royal College (England) 1971. Board eligible. Group, partnership, solo, hospital-based salaried position. Available.

Martin S. Lerman, M.D., 7601 Holmes Run Drive, Falls Church, Virginia 22040. Georgetown. Board eligible. Group, partnership, or solo. Available July 1977.

Mark A. Sullivan, M.D., 2834 Midvale Avenue, Philadelphia, Pennsylvania 19129. Cornell 1972. Subspecialty, gastroenterology. Board certified. Group or partnership. Available July 1977.

James L. Stammer, M.D., 5314 La Cieniga Circle, San Antonio, Texas 78233. CMDNJ 1970. Subspecialty, gastroenterology. Board eligible. Group, partnership. Available August 1977.

Chia Yian Chou, M.D., 86-31 57th Avenue, Elmhurst, New York 11373. Taipei (Taiwan) 1970. Board eligible. Solo or group. Available July 1977.

OCCUPATIONAL MEDICINE — Alexander A. Boytar, M.D., 3101 Skyline Dr., Wilmington De. 19808. Budapest, 1947. Board certified — (IM). Industrial medicine, pharmaceutical or chemical company, group of industrial physicians. Available.

OPHTHALMOLOGY — George R. Zambelli, M.D., 1353 Bradshire Road, Columbus, Ohio. St. Louis University. Board eligible. Solo, partnership, group. Available July 1977.

Edward B. Feinberg, M.D., 2819 Renfrew Avenue, Ann Arbor, Michigan 48105. Mt. Sinai 1971. Board eligible. Group, association, or partnership. Available July 1977.

Howard B. Goldman, M.D., 160 Cabrini Boulevard, New York, New York 10033. NYU (Bellevue) 1973. Solo, associate, or group. Available July 1977.

ORTHOPEDICS — A. M. Arain, M.D., 21 Narraticon, Deptford 08096. King Edward, Lahore (Pakistan) 1962. Board eligible. Solo. Available April 1977.

PATHOLOGY — Azhar Saifuddin, M.D., Cambridge Arms Apts., Route 9, Box 644-A, Florence, Alabama 35630. Dow Medical College, Karachi (Pakistan) 1966. Board certified. Group, partnership, solo. Available.

Him G. Kwee, M.D., 207 Duke of York Lane, Apt. T-1, Cockeysville, Md. 21030. Airlangga (Indonesia) 1964. Group. Available July 1977.

Charles K. Allam, M.D., 236 Fuller Terrace, Orange 07050. French Faculty of Medicine, Beirut (Lebanon) 1961. Board certified. Group or partnership (hospital-based). Available.

PEDIATRICS — David Spiller, M.D., 401 East 86th Street, Apt. 11-K, New York 10028. New York Medical College 1972. Board eligible. Solo. Available.

Stewart Gabel, M.D., 5805 Tivoli Circle, Richmond, Virginia 23227. Albert Einstein 1968. Board eligible. Group or hospital setting. Available.

Mark B. Levin, M.D., 5100 Highbridge St., Apt. 505, Fayetteville, New York 13066. SUNY (Syracuse) 1974. Group, partnership, solo. Available July 1977.

Elizabeth W. Dow, M.D., 3705-B Woodmont Blvd., Nashville, Tenn. 37215. Vanderbilt 1972. Board eligible. Special interest in adolescence. Group, student health service, partnership, hospital. Available.

Stephen Schlesinger, M.D., 2309 Tarleton Drive, Charlottesville, Virginia 22901. SUNY (Buffalo) 1970. Board certified. Any type practice. Available July 1977.

Robert Sasson, M.D., 142 Longmeadow Apartments, Cornwells Heights, Pennsylvania 19020. SUNY (Downstate). Board eligible. Group, partnership, or solo. Available July 1977.

Francis DiBona, M.D., 265 Parklake, Ann Arbor, Michigan 48103. Wisconsin 1969. Subspecialty, nephrology. Board certified. Large group (hemodialysis). Available September 1977.

Raymond Kahn, M.D., 4635 Clanranald, Montreal, Canada H3X 2R8. McGill 1973. Board eligible. Group partnership, or solo. Available July 1977.

PSYCHIATRY — Melvin W. Cohen, M.D., 681 Clarkson Avenue, Brooklyn, New York 11203. Meharry 1968. Board eligible. Clinic, hospital-based, or group. Available January 1977.

PULMONARY MEDICINE — Donald L. Epstein, M.D., 9 Winding Brook Drive, Apt. 2F, Guilderland, New York 12084. CMDNJ 1972. Board eligible. Group, partnership, solo. Available July 1977.

Lawrence S. Slotnick, M.D., 2157 Hawaii Avenue, Forrestal Village, Great Lakes, Illinois 60088. SUNY (Downstate) 1970. Group or hospital. Available July 1977.

RADIOLOGY — Benjamin Anthony Giella, Jr., M.D., Box 1316 Hopkinson House, Washington Square South, Philadelphia, Pennsylvania 19106. University of Pennsylvania 1970. Special interest — diagnostic radiology. Board eligible. Hospital, group, or partnership. Available July 1977.

Nanjappa C. Sadasivan, M.D., 16520 Schaefer Street, Apt. #7, Detroit, Michigan 48235. Stanley (India) 1969. Special interest — ultrasound and diagnostic radiology. Board eligible. Any type practice. Available July 1977.

Phyllis R. Jarvis, M.D., 5116 Professional Drive, Apt. 88, Wichita Falls, Texas 76302. NYU 1970. Special interest — diagnostic and pediatric radiology. Board certified. Group, partnership, academic. Available July 1977.

SURGERY — Henry H. Bard, M.D., 10 Medical Plaza, Glen Cove, New York 11542. Columbia 1948. Board certified. Partnership, full time. Available.

David L. Walrath, M.D., 12 Polo Lane, Westbury, New York 11590. CMDNJ (Newark) 1970. Partnership or small group. Available July 1977.

Peter A. Jarvis, M.D., 5116 Professional Drive, Wichita Falls, Texas 76302. Cornell 1970. Board certified. Group, partnership. Available July 1977.

UROLOGY — David H. Kauder, M.D., 4016 Grimes Avenue South, Edina, Minnesota 55416. SUNY, Downstate 1971. Board eligible. Group or partnership. Available June 1977.

Stephan Jay Sweitzer, M.D., 350 Curtin Drive, Lexington, Kentucky 40503. Vanderbilt University 1970. Board eligible. Group or association leading to partnership. Available July 1977.

Stanley M. Bernstein, M.D., 350 W. 57th St., Apt. 4-G, New York 10019. NYU 1968. Board eligible. Any type of practice. Available January 1977.

Syed S. Mada, M.D., 260-18 73rd Avenue, Glen Oaks, New York 11004. Punjab (Pakistan) 1967. Board eligible. Any type of practice. Available July 1977.

Steven Ross, M.D., 4469 Chestnut Ridge Road, Tonawanda, New York 14150. CMDNJ 1972. Board eligible. Group, partnership, or solo practice. Available July 1977.

Charles Bamberger, M.D., 2775 Bender Avenue, Akron, Ohio 44319. University of Chile 1969. Partnership or solo practice. Available July 1977.

LETTERS TO THE JOURNAL

Am I My Brother's Keeper?

September 24, 1976

Dear Doctor Todd:

For an organization to be truly successful it must address the concerns of all of its members. The recent adoption by the House of Delegates of the mandatory \$200 professional liability assessment legitimately addresses the concern of those physicians who must obtain professional liability insurance and focuses the Society's activities on this crisis.

This action, however, will tend, in my opinion, to drive occupational health physicians, public health physicians, physician educators, and other physicians not needing personally to obtain liability insurance, out of The Medical Society of New Jersey. In order for the Society truly to represent New Jersey's physicians, it must have the support and involvement of *all* physicians regardless of their need for professional liability insurance.

In writing this letter, I am by no means trying to minimize the current professional liability crisis. I do feel, however, that those physicians who will benefit from this activity should "mandatorily" support it and other physicians should continue in the voluntary assessment category.

I would greatly appreciate the Board's reconsideration of this matter.

(signed) Donald S. Kwalick, M.D.,
Assistant Commissioner, N.J. Dept. Health

October 7, 1976

Dear Doctor Kwalick:

Thank you for your letter of September 24, relating to the mandatory assessment for

professional liability control. We are sorely aware that there are many physicians in full-time employment for whom liability insurance is provided as a condition of their employment. We do not feel, however, that this circumstance should exempt anyone from a sincere interest in assuring equal ability for all physicians to practice under the best possible conditions. Therefore, it has been the decision of the House of Delegates of The Medical Society of New Jersey that all regular dues-paying members will be expected to contribute toward the well-being of the profession.

(Signed) James S. Todd, M.D.
Chairman, Board of Trustees

Counter Suit?

September 24, 1976

Dear Sir:

Because of the ease with which a plaintiff may institute a malpractice suit at no cost to himself, with nothing to lose and everything to gain, a large number of unjustifiable suits are started. Though it has no effect on the plaintiff, it is a traumatic experience to the physician.

I think that there is a way to combat this and that is by means of the countersuit to be started at the same time as the suit takes place. Both the suit and countersuit are to be tried at the same trial. If a plaintiff incurs a risk if he should lose his case, I think he would think twice before he starts an action.

However, this would incur an expense on the part of the physician. I suggest that a fund be instituted to which each member of the Society contributes ten dollars which would go to the expense incurred in a countersuit. Any amount above attorney fees won in a countersuit would revert back to this fund.

I am sure that this action will cut the number of malpractice cases started and secondarily decrease malpractice insurance rates.

(signed) Harry Arons, M.D.

ANNOUNCEMENTS

Course in Pediatric Clinical and Theoretical Allergy

In cooperation with the New Jersey Medical School, CMDNJ, the Children's Hospital of Newark is sponsoring a review course in clinical problems in pediatric allergy designed for pediatricians, family physicians, and allergists. The program runs from September through May. Lectures are held each Thursday from 11 a.m. to 12 noon in the Chapel Conference Room at United Hospitals of Newark. In addition a pediatric allergy clinic will be held from 8:30 to 10 a.m. on each of these days, and from 12 noon to 1 p.m. there will be a pediatric conference. Hour-for-hour credit will be awarded in Category I of the AMA Physician's Recognition Award. Tuition is \$100. For information, please address a communication to Arthur F. Fost, M.D., Director of Allergy, Children's Hospital of Newark, 15 South 9th Street, Newark 07107.

The schedule for November and December is as follows:

Nov. 4 — Evaluations of Immunology Reactions
Nov. 11 — Pathophysiology of Asthma
Nov. 18 — Pulmonary Function by Bronchspirometry

Dec. 2 — Blood Gases
Dec. 9 — Asthma
Dec. 14 — Inhalation Therapy
Dec. 23 — Pulmonary Conferences
Dec. 30 — Hospital Management of Asthma

Neurosurgical Conferences

Under the auspices of the Division of Neurological Surgery of the Martland Hospital Unit, New Jersey Medical School-CMDNJ, weekly (Thursdays) neurosurgical conferences have been scheduled at the Veterans Administration Hospital in East Orange. The sessions convene at 4 p.m. In addition, invited visiting-professor lectures will be presented at 3 p.m., immediately preceding the conferences, on selected dates. The first one was scheduled for

November 4, the second will be held November 18, and two are scheduled for 1977 — January 20 and February 10. For additional information, please communicate with Abbott J. Krieger, M.D., Professor and Director of Neurological Surgery, Martland Hospital Unit-CMDNJ, 65 Bergen Street, Newark 07107.

Psychiatric Association Sessions

The Tri-County Chapter of the New Jersey Psychiatric Association will present the following program on December 8:

Depressive Personality and Affect Reflected in Dreams: A Basis for Psychotherapy
Walter Bonime, M.D.

The group convenes at 6:30 p.m. at the Mayfair Farms, West Orange. Dinner for a member and spouse is \$24.50; for non-members the charge is \$28.50 per couple. Co-sponsor of the meeting is the New Jersey Academy of Psychoanalysis. Two credit hours will be awarded in Category I of the AMA Physician's Recognition Program. For further information, please communicate with Harvey Shwed, M.D., Secretary of the Chapter, 268 High Street, Newark 07102.

Air Pollution and Patient Management

On December 3 in conjunction with the AMA Clinical Conference in Philadelphia there has been arranged a CME course on Air Pollution and Patient Management. The course is designed to educate physicians concerning air pollution and its direct and indirect effects on patients. Selected lecture topics include the nature of air pollution in the United States, air pollution and pulmonary physiology, sulfates and particulates, and oxides of nitrogen and carbon monoxide. The program is acceptable for Category I credit in the AMA Physician's Recognition Award. Registration fee is \$25

which includes a syllabus. Additional information and an advance copy of the program is available from the AMA Department of Environmental, Public, and Occupational Health, 535 North Dearborn Street, Chicago, Illinois 60610.

Program on Chronic Lung Disease

On December 16, at the Children's Hospital in Newark, the New Jersey Allergy Society, in cooperation with the Academy of Medicine and Schering Corporation, will offer a program on chronic lung disease. Subjects to be presented include: hypersensitive pneumonitis, definitions of asthma, chronic bronchitis and emphysema, tuberculosis, and inhaled steroids in reversible obstructive lung disease. Five credit hours will be awarded in category I of the AMA Physician's Recognition Award. Reservations for luncheon (\$5) should be forwarded immediately to Michael S. Mattikow, M.D., 1777 Hamburg Turnpike, Wayne, New Jersey 07470.

Seminar in Pediatric Neurology

From January 17 to 21, 1977, at the Konover Hotel, Miami Beach, Florida, a graduate seminar in pediatric neurology will be held under the auspices of the Division of Pediatric Neurology, University of Miami School of Medicine. Topics to be covered include: neurologic manifestations of systemic disease,

infections of the central nervous system, neurologic emergencies, and pediatric neuropsychiatric diseases. The course is acceptable for 21 Category I credit hours by the AMA. Registration fee is \$175; \$75 for residents. Advance registration is required no later than December 19, and a hotel reservation card will be sent upon receipt of the registration fee. For additional information, please write to Postgraduate Seminar in Pediatric Neurology, 1200 NW 10th Avenue, Miami, Florida 33136 — (305) 324-0841.

Gastrointestinal Endoscopy Organization Formed

Announcement is made of the recent formation of the New Jersey Society for Gastrointestinal Endoscopy, a subsidiary of the New Jersey Gastroenterological Society. The listed purposes are:

1. To further the knowledge and treatment of gastrointestinal disease through the use of endoscopic instruments;
2. To further the teaching of gastrointestinal endoscopic methods of examination; and
3. To assure proper standards of excellence in the performance of gastrointestinal endoscopy.

Physicians interested may apply for membership to the Society's executive offices, 2424 Morris Avenue, Union, New Jersey 07083.

MEETINGS OF MEDICAL INTEREST

This listing is compiled through the cooperation of the Committee on Medical Education of The Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the College of Medicine and Dentistry of New Jersey. For information on accreditation, please contact the sponsoring organization(s).

Nov.

- 17 **Biofeedback in Psychiatry**
1-2 p.m., New Jersey Medical School, Newark
(Sponsored by CMDNJ and AMNJ)
- 17 **Hyperlipidemia**
- 24 **Cardiovascular Applications of Nuclear Medicine**
10:30-11:30 a.m. — Clara Maass Memorial Hospital, Belleville
(Sponsored by Clara Maass Memorial Hospital and AAFP)
- 17 **Growth and Development-Mental and Emotional**
- 18 **Fx Knee and Lower Leg**

- 19 **Things Respiratory**
- 22 **GU Trauma**
- 23 **Esophagus and Stomach**
- 24 **Puerperium and Post Partum Care**
- 25 **Overweight and Obesity**
- 26 **Mechanical Bowel Obstruction**
- 29 **Visiting Professor Day**
- 30 **Marital Problems**
12 noon — Hunterdon Medical Center, Flemington
(Sponsored by Hunterdon Medical Center)
- 17 **Medical Problems Disguised as Dermatologic**
1-3 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital and AMNJ)

- 17 **Shock**
1 p.m. — Trenton Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
- 17 **Hepatitis B Immune Globulin in Hepatitis B Infections**
9:30-11 a.m. — Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital)
- 17 **Effect of Age on the Response to Cardio-Active Agents**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
- 17 **Arthroscopy**
8 a.m. — Southern Ocean County Hospital, Manahawkin
(Sponsored by Burlington County Memorial Hospital and AAFP)
- 17 **Bullae, Blebs, Cysts: Surgical Considerations**
11:30 a.m.-12:30 p.m. — V.A. Hospital, East Orange
(Sponsored by East Orange V.A. Hospital)
- 17 **Intestinal Absorption and Malabsorption**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 17 **Special Rounds, General Surgery and Specialties**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 17 **Neurosurgical Treatment of Pain**
1-2 p.m. — V.A. Hospital, Lyons
(Sponsored by Lyons V.A. Hospital)
- 18 **Pulmonary Function by Bronchspirometry**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
- 18 **Dermal Ulcers and Necrotic Burns**
12 noon-1 p.m. — St. Mary's Hospital, Orange
(Sponsored by St. Mary's Hospital)
- 18 **Case Presentation**
- 23 **The Day Hospital Milieu**
11 a.m.-12 noon — Greystone Park Psychiatric Hospital
(Sponsored by Greystone Park Psychiatric Hospital and AMNJ)
- 18 **Fluid and Electrolyte Disorders**
7:30-8:30 a.m. — St. Elizabeth Hospital, Elizabeth
(Sponsored by St. Elizabeth Hospital and AMNJ)
- 18 **Interstitial Nephritis**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 18 **Diabetes Mellitus**
12 noon — Carrier Clinic, Belle Mead
(Sponsored by Carrier Clinic)
- 18 **Uses and Abuses of Estrogen Therapy**
5-6:30 p.m. — Somerset Hospital, Somerville
(Sponsored by Somerset Hospital)
- 18 **Regional Chest Conference**
7:30-9:30 p.m. — Martland Hospital, Newark
(Sponsored by New Jersey Thoracic Society)
- 18 **Topics in Neurosurgery**
4-5 p.m. — VA Hospital, East Orange
(Sponsored by CMDNJ, VA Hospital, East Orange, and AMNJ)
- 19 **Gastrointestinal Bleeding**
12 noon — Freehold Area Hospital
(Sponsored by AMNJ and AAFP)
- 19 **Clinical Endocrinology**
4:30 p.m. — Holiday Inn, Deepwater
(Sponsored by Salem County Medical Society, AMNJ and AAFP)
- 19 **Psychodynamics and Psychotherapy of Psychiatric Disorders**
1:30-2:30 p.m. — Trenton Psychiatric Hospital
Neuroanatomy and Neuropathology
2:45-3:45 p.m. — Trenton Psychiatric Hospital
Clinical Neurology
4-5 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital)
- 21 **Review of Pneumonia**
10-10:30 a.m. — Passaic General Hospital
Common Mistakes in Bacteriology Laboratories
10:30-11 a.m. — Passaic General Hospital
Fever of Unknown Origin
11 a.m.-12 noon — Passaic General Hospital
(Sponsored by Hahnemann Medical College)
- 23 **Dermatology**
12 noon — Hospital Center at Orange
(Sponsored by AMNJ and AAFP)
- 23 **Psychopathology of Sexual Dysfunction**
2-4 p.m. — Camden County Psychiatric Hospital
(Sponsored by Camden County Psychiatric Hospital)
- 24 **Occupational Medicine**
3-4:30 p.m. — Fair Oaks Hospital, Summit
(Sponsored by Fair Oaks Hospital)
- 24 **Hyperlipemia, 1976**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 24 **Special Rounds, Internal Medicine**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 24 **Clinical Immunology**
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
- 24 **Rheumatoid Disease**
9:30-11 a.m. — Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital)
- 24 **Mycosis Fungoides and Relevant Skin Lymphomas**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
- 24 **Laparoscopy**
12 noon-1 p.m. — Englewood Hospital
(Sponsored by Englewood Hospital)
- 24 **Management of the Hypertensive Patient**
10:30 a.m.-12 noon — Passaic General Hospital
(Sponsored by Hahnemann Medical College)

Dec.

- 1 **Swine Flu — 1976**
9:30-11 a.m. — Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital)
- 1 **Hypoglycemia As a Clinical Problem**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
- 1 **Advances in Nutrition**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 1 **Special Rounds, Pediatrics**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 1 **Management of Diabetes Mellitus**
1:30-2:30 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital)
- 1 **Selected Topics in Gastroenterology**
8-10 p.m. — Overlook Hospital, Summit
(Sponsored by N.J. Gastroenterology Society)
- 1 **Psychopharmacology of Depression**
- 15 **Neurotransmitters**
1-2:30 p.m., New Jersey Medical School, Newark
(Sponsored by CMDNJ and AMNJ)
- 1 **Fall Refresher Course**
8:30 a.m.-4:30 p.m., West Jersey Hospital, Voorhees
(Sponsored by CMDNJ, Rutgers and AAFP)
- 1 **Pre-infarction Angina**
- 8 **Chemotherapy of Gynecologic Tumors**
- 15 **Special Applications of Radiation Therapy**
10:30-11:30 a.m., Clara Maass Hospital, Belleville
(Sponsored by Clara Maass Hospital and AAFP)
- 1 **Clinical Immunology**
- 8 **Allergy**
- 15 **Infectious Disease in Community Hospital**
1 p.m., Christ Hospital
(Sponsored by Christ Hospital)
- 2 **Fluid and Electrolyte Disorders**
- 9 **Fluid and Electrolyte Disorders**
7:30-8:30 a.m., St. Elizabeth Hospital, Elizabeth
(Sponsored by St. Elizabeth Hospital and AMNJ)
- 2 **The Day Hospital Milieu**
- 9 **Case Presentation**
- 16 **Institutionalization — The Effect on the Patient**
11 a.m.-12 noon, Greystone Park Psychiatric Hospital
(Sponsored by Greystone Park Psychiatric Hospital and AMNJ)
- 2 **Medical Education for Whom**
8:30-10 p.m., Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital, Bergen County Medical Society and AMNJ)
- 2 **Topics in Neurosurgery**
- 9 **4-5 p.m. — VA Hospital, East Orange**
(Sponsored by CMDNJ, VA Hospital, East Orange, and AMNJ)
- 2 **Urinary Tract Infection**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 2 **Update in Psychopharmacology**
12 noon — Carrier Clinic, Belle Mead
(Sponsored by Carrier Clinic)
- 2 **Blood Gases**
11-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
- 3 **Surgical Management of Ulcerative Colitis**
8:30 a.m. — United Hospitals of Newark
(Sponsored by AMNJ and AAFP)
- 3 **Psychodynamics and Psychotherapy of Psychiatric Disorders**
1:30-2:30 p.m. — Trenton Psychiatric Hospital
- 3 **Neuroanatomy and Neuropathology**
2:45-3:45 p.m. — Trenton Psychiatric Hospital
Clinical Neurology
4-5 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital)
- 3 **Melanoma and Immunologic Advances**
12 noon-1 p.m. — St. Mary's Hospital, Orange
(Sponsored by St. Mary's Hospital and AMNJ)
- 4 **Surgical Scientific Sessions**
9 a.m.-4:30 p.m. — CMDNJ-Rutgers Medical School
(Sponsored by N.J. Chapter, ACS)
- 5 **Diagnostic Aspects of Pleural Effusion**
10:30-11 a.m. — Bayonne Hospital
Cancer of the Lung
11 a.m.-12 noon — Bayonne Hospital
- 19 **Clinical Application of Arterial Blood Gases**
10-11 a.m. — Bayonne Hospital
Bronchoactive Drugs
11-11:30 a.m. — Bayonne Hospital
Diagnostic Techniques of the Lung
11:30-12 noon — Bayonne Hospital
(Sponsored by CMDNJ, Rutgers, and Bayonne Hospital)
- 6 **Laboratory Interpretations**
1-3 p.m. — Ancora Psychiatric Hospital, Hammonton
(Sponsored by AMNJ and AAFP)
- 6 **Alcoholism**
8 p.m. — Community Memorial Hospital, Toms River
(Sponsored by AMNJ and AAFP)
- 7 **Congestive Heart Failure**
11 a.m. — Greystone Park Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
- 7 **Lecture Series**
11 a.m. — Overlook Hospital, Summit
(Sponsored by Overlook Hospital and AAFP)
- 8 **Hormones and Cancer**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)

- 8 **Screening for Colon Cancer**
9:30-11 a.m. — Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital)
- 8 **Philosophical Background of Transactional Analysis, Part I**
3-4:30 p.m. — Fair Oaks Hospital, Summit
(Sponsored by Fair Oaks Hospital)
- 8 **Psychoactive Medications**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 8 **Special Rounds, Obstetrics — Gynecology**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 8 **Chronic Renal Failure**
1:30 p.m. — Runnells Hospital, Berkeley Heights
(Sponsored by AMNJ and AAFP)
- 8 **Emergency Medicine**
1-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
- 8 **Antibiotics: Use and Misuse**
- 22 **Management of Trauma Patient**
10:30 a.m.-12 noon — Passaic General Hospital
(Sponsored by Hahnemann Medical College and AAFP)
- 8 **Methadone Therapy**
1:30-3:30 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital and AMNJ)
- 8 **Depressive Personality and Affect Reflected in Dreams**
8:30-10:30 p.m. — Mayfair Farms, West Orange
(Sponsored by N.J. Psychiatric Association and AMNJ)
- 8 **Advances in Treatment of Bronchial Asthma**
1-3 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital and AMNJ)
- 9 **Diagnosis and Management of GI Bleeding**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 9 **PSRO: Psychiatry's Situation Remains Obscure**
12 noon — Carrier Clinic, Belle Mead
(Sponsored by Carrier Clinic)
- 9 **Hyperlipidemia**
5-6:30 p.m. — Somerset Hospital, Somerville
(Sponsored by Somerset Hospital)
- 9 **Definitions of Asthma**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
- 10 **Liver Function**
1:30-4:30 p.m. — Martland Hospital, Newark
(Sponsored by CMDNJ and AMNJ)
- 14 **Hematuria and Its Causes**
8 a.m. — S. Ocean Co. Hospital, Manahawkin
(Burlington County Memorial Hospital and AAFP)
- 14 **Burns**
8 p.m. — Paul Kimball Hospital, Lakewood
(Sponsored by AMNJ and AAFP)
- 14 **Thyroid Diseases**
9 p.m. — Bayonne Hospital
(Sponsored by AMNJ and AAFP)
- 14 **Vaginal Surgery**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 14 **Optics for the Clinical Ophthalmologist**
- 15 4:30-6:30 p.m. — 15 So. 9th St., Newark
- 16 (Sponsored by Associated Eye Residencies of New Jersey AMNJ)
- 15 **Neurology in a Psychiatric Setting**
1-2:30 p.m. — Marlboro Psychiatric Hospital
(Sponsored by Marlboro Psychiatric Hospital and AMNJ)
- 15 **Infectious Disease in a Community Hospital**
1-3 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital)
- 15 **Complications of Alcoholism**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 15 **Hypersensitivity and Immunity**
11:30 a.m.-12:30 p.m. — V.A. Hospital, East Orange
(Sponsored by East Orange V.A. Hospital)
- 15 **Special Rounds, General Surgery and Specialties**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 15 **Psychiatric Aspect of Endocrine Disorders**
1 p.m. — Trenton Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
- 15 **Prolapse of the Mitral Valve**
9:30-11 a.m. — Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital)
- 15 **Facial Trauma and Reconstructive Surgery**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
- 16 **Inhalation Therapy and O₂ and Mist Therapy**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
- 16 **Low Back Pain**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 16 **Common Ear, Nose and Throat Problems**
9:30-10:45 p.m., Woodbury Country Club, Cooper St., Woodbury
(Sponsored by Gloucester County Medical Society and AMNJ)
- 16 **Regional Chest Conference, Northern New Jersey**
7:30-9:30 p.m. — Overlook Hospital, Summit

(Sponsored by New Jersey Thoracic Society and AMNJ)

- 17 **Glomerulonephritis**
9-10 a.m. — St. Francis Medical Center, Trenton
(Sponsored by Hahnemann Medical College and AAFP)
- 17 **Bleeding Diseases**
12 noon — Freehold Area Hospital
(Sponsored by AMNJ and AAFP)
- 21 **Infectious Diseases**
12 noon — St. Mary's Hospital, Orange
(Sponsored by AMNJ and AAFP)
- 21 **Chronic Renal Failure**
12 noon — Hospital Center at Orange
(Sponsored by AMNJ and AAFP)
- 21 **Contact B-Scan Ultra-Sonography**
8-10 p.m. — Englewood Men's Club
(Sponsored by Englewood Surgical Society and AMNJ)
- 22 **Gastrointestinal Bleeding**
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
- 22 **Computerized Tomography**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
- 22 **When to Refer to the Geneticist**
9:30-11 a.m. — Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital)
- 22 **Headaches in Children**
8 a.m. — Southern Ocean County Hospital, Manahawkin
(Sponsored by Burlington County Memorial Hospital and AAFP)
- 22 **Philosophical Background of Transactional Analysis, Part II**
3-4:30 p.m. — Fair Oaks Hospital, Summit
(Sponsored by Fair Oaks Hospital)
- 22 **The Aging Heart**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 22 **Special Rounds, Internal Medicine**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 23 **Pediatric Pulmonary Conference**
11-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
- 29 **Clinical Pathology Conference**
9:30-11 — Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital)
- 30 **Hospital Management of Childhood Asthma**
11 a.m.-12 noon — United Hospitals of Newark
(Children's Hospital of Newark and CMDNJ)

1977
Jan.

- 3 **Diagnosis and Treatment of Shock**
1 p.m. — Ancora Psychiatric Hospital, Hammonton
(Sponsored by AMNJ and AAFP)
- 3 **Pacemakers**
8 p.m. — Community Memorial Hospital, Toms River
(Sponsored by AMNJ and AAFP)
- 4 **Coronary Artery Disease**
11 a.m. — Greystone Park Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
- 5 **Cancer Research**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 5 **Special Rounds, Pediatrics**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 5 **Clinical Endocrinology**
3 p.m. — Fair Oaks Hospital, Summit
(Sponsored by AMNJ and AAFP)
- 5 **Fiberoptic Bronchoscopy**
9:30-11 a.m. — Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital)
- 5 **Myasthenia Gravis**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
- 5 **Selected Topics in Gastroenterology**
8-10 p.m. — Medical Center, Princeton
(Sponsored by N.J. Gastroenterology Society)
- 5 **Seizures in Children and Adolescents**
- 19 **Approach to Thyroid Nodule**
10:30-12 noon — Passaic General Hospital
(Sponsored by Hahnemann Medical College and AAFP)
- 5 **Emergency Medicine**
- 12 **Use of Local Anesthesia in the High Risk Surgical Patient**
- 26 **Arthritis**
1-3 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital and AMNJ)
- 6 **Topics in Neurosurgery**
- 13 4-5 p.m. — VA Hospital, East Orange
- 20 *(Sponsored by CMDNJ, VA Hospital, East Orange and AMNJ)*
- 27 **Tranquilizers in the Age of Anxiety**
8:30-10 p.m. — Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital, Bergen County Medical Society and AMNJ)
- 6 **The Allergic Child**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)

- 6 **Workshop on Hypertension**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 7 **Indications for Cardiac Surgery in Rheumatic and Congenital Heart Disease**
8:30 a.m. — United Hospitals of Newark
(Sponsored by AMNJ and AAFP)
- 9 **Renal Function Tests**
10 a.m.-10:30 a.m. — Bayonne Hospital
Acute Renal Failure
10:30-11 a.m. — Bayonne Hospital
Chronic Renal Failure
11-11:30 a.m. — Bayonne Hospital
Renin
11:30 a.m.-12 noon — Bayonne Hospital
(Sponsored by Bayonne Hospital and CMDNJ)
- 10 **Management of Carcinoma of Urinary Bladder**
12 noon-1 p.m. — Overlook Hospital, Summit
(Sponsored by Overlook Hospital and AMNJ)
- 11 **Pre-Hospital Coronary Care**
8 p.m. — Paul Kimball Hospital, Lakewood
(Sponsored by AMNJ and AAFP)
- 11 **Sports Medicine**
9 p.m. — Bayonne Hospital
(Sponsored by AMNJ and AAFP)
- 11 **Abnormal Pap Smear in Young Woman**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 12 **Weakness and Fatigue**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 12 **Special Rounds, Obstetrics — Gynecology**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 12 **Clinical Immunology**
11:30 a.m. — Rahway Hospital
(Sponsored by AMNJ and AAFP)
- 12 **Surgery in Ulcerative Colitis**
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
- 12 **Endocrine Diseases of the Male and Female Gonads**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
- 13 **Chronic Chest Disease in Children**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMNJ)
- 13 **Chronic Pulmonary Obstructive Disease**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 18 **Endotoxic Shock**
12 noon — St. Mary's Hospital, Orange
(Sponsored by AMNJ and AAFP)
- 18 **Regional Chest Conference, Northern New Jersey**
7:30-9:30 p.m. — St. Joseph's Hospital and Medical Center, Paterson
(Sponsored by New Jersey Thoracic Society and AMNJ)
- 19 **Clinical Psychiatry Series**
1 p.m.-2:30 p.m. — New Jersey Medical School, Newark
(Sponsored by CMDNJ and AMNJ)
- 19 **Alcoholism**
1 p.m.-2:30 p.m. — Marlboro Psychiatric Hospital
(Sponsored by Marlboro Psychiatric Hospital and AMNJ)
- 19 **Hepatitis**
1 p.m. — Trenton Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
- 19 **Acid Base Disturbances**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
- 19 **Out-Patient Management of COPD**
11:30 a.m.-12:30 p.m. — V.A. Hospital, East Orange
(Sponsored by East Orange V.A. Hospital)
- 19 **Pathophysiology of Anemia**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 19 **Special Rounds, General Surgery and Specialties**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 20 **Asthma**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
- 20 **Sex Therapy — Non-Orgasmic Female**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 20 **Immunologic and Pathophysiological Aspects of Asthma**
5-6:30 p.m. — Somerset Hospital, Somerville
(Sponsored by Allergy Society)
- 21 **Sex Therapy — Impotent Male**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 21 **Clinical Immunology**
12 noon — Freehold Area Hospital
(Sponsored by AMNJ and AAFP)
- 21 **Bleeding Diseases**
4:30 p.m. — Holiday Inn, Deepwater
(Sponsored by Salem County Medical Society, AMNJ and AAFP)
- 23 **Clinical Approach of Acid-Base Disturbances**
10-11 a.m. — Bayonne Hospital
Case Reviews of Acid-Base Disorders
11 a.m.-12 noon — Bayonne Hospital
(Sponsored by Bayonne Hospital and CMDNJ)

- 25 **Child Abuse and Neglect**
8 p.m. — Warren Hospital, Phillipsburg
(Sponsored by AMNJ and AAFP)
- 26 **Hepatitis**
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
- 26 **Malignant Melanomas**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
- 26 **Gram Negative Infections in Surgery**
9-11 a.m. — Auditorium, Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 26 **Special Rounds, Internal Medicine**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 27 **Pediatric Pulmonary Conference**
11-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
- Feb.
- 1 **Pre-Hospital Coronary Care**
11 a.m. — Greystone Park Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
- 2 **Laboratory Interpretations**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 2 **Special Rounds, Pediatrics**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 2 **Gastrointestinal Bleeding**
1 p.m. — Christ Hospital, Jersey City
(Sponsored by AMNJ and AAFP)
- 2 **Gout and Pseudogout**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
- 2 **The Tasks of Psychiatry**
- 16 **Biology and Gender Role**
1-2:30 p.m. — New Jersey Medical School, Newark
(Sponsored by CMDNJ and AMNJ)
- 2 **Ulcerative Colitis and Ileitis**
- 16 **Treatment of Common Dermatoses**
10:30-12 noon — Passaic General Hospital
(Sponsored by Hahnemann Medical College and AAFP)
- 3 **Topics in Neurosurgery**
- 10 4-5 p.m. — VA Hospital, East Orange
17 (Sponsored by CMDNJ, VA Hospital, East Orange,
24 and AMNJ)
- 3 **Hypersensitivity Pneumonitis**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
- 3 **Low Renin Hypertension**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 4 **Laboratory Interpretations**
8:30 a.m. — United Hospitals of Newark
(Sponsored by AMNJ and AAFP)
- 4 **Dilemmas in Informed Consent**
8:30-10 p.m. — Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital, Bergen County Medical Society and AMNJ)
- 7 **Married Couple with Severe Sexual Difficulties**
8-10 p.m. — 11 Ridgewood Ave., Glen Ridge
(Sponsored by Essex Psychiatric Seminar and AMNJ)
- 7 **Coronary Artery Disease**
1 p.m. — Ancora Psychiatric Hospital, Hammonton
(Sponsored by AMNJ and AAFP)
- 7 **Vascular Surgery**
8 p.m. — Community Memorial Hospital, Toms River
(Sponsored by AMNJ and AAFP)
- 8 **Cerebral Vascular Disease**
8 p.m. — Paul Kimball Hospital, Lakewood
(Sponsored by AMNJ and AAFP)
- 8 **Acute Renal Failure**
9 p.m. — Bayonne Hospital
(Sponsored by AMNJ and AAFP)
- 8 **Ovarian Tumors**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 9 **Genetic Counseling**
1-3 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital and AMNJ)
- 9 **Management of Hepatitis**
11:30 a.m. — Rahway Hospital
(Sponsored by AMNJ and AAFP)
- 9 **Current Chemotherapy**
1:30 p.m. — Runnells Hospital, Berkeley Heights
(Sponsored by AMNJ and AAFP)
- 9 **Fluid and Electrolyte Imbalance**
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
- 9 **Hyperaldosteronism**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
- 9 **Common Intestinal Parasites**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 9 **Special Rounds, Obstetrics — Gynecology**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 9 **Psychiatry — Studies in the Subjective Sense of Time**
1-2:30 p.m. — Marlboro Psychiatric Hospital
(Sponsored by Marlboro Psychiatric Hospital and AMNJ)
- 10 **Aeroallergens, Air Pollutants and Respiratory Disease**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)

- 10 **Renal Transplantation**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
 - 11 **Pancreatitis**
9-10 a.m. — St. Francis Hospital, Trenton
(Sponsored by Hahnemann Medical College and AAFP)
 - 15 **Thyroid Disease**
12 noon — St. Mary's Hospital, Orange
(Sponsored by AMNJ and AAFP)
 - 15 **Anesthetic Air Pollution in the Operatory**
8:30 p.m. (preceded by dinner at 6 p.m.) — Fireside Inn, Rochelle Park
(Sponsored by Dental Section, AMNJ)
 - 16 **Thanatology**
3 p.m. — Fair Oaks Hospital, Summit
(Sponsored by AMNJ and AAFP)
 - 16 **The Violent Patient**
1 p.m. — Trenton Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
 - 16 **Congestive Heart Failure**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
 - 16 **Clinical Physiology of the Control of Breathing**
11:30 a.m.-12:30 p.m. — V.A. Hospital, East Orange
(Sponsored by East Orange V.A. Hospital)
 - 16 **Psychosomatic Problems in Children**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
 - 16 **Special Rounds, General Surgery and Specialties**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 17 **Molds and Pollens**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
 - 17 **Contact Dermatitis**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
 - 17 **Cardiovascular Aspects of Jogging**
5-6:30 p.m. — Somerset Hospital, Somerville
(Sponsored by Somerset Hospital)
 - 18 **Sports Medicine**
4:30 p.m. — Holiday Inn, Deepwater
(Sponsored by Salem County Medical Society, AMNJ and AAFP)
 - 18 **Blood Gases**
12 noon — Freehold Area Hospital
(Sponsored by AMNJ and AAFP)
 - 22 **Current Treatment of Burns**
8 p.m. — Warren Hospital, Phillipsburg
(Sponsored by AMNJ and AAFP)
 - 23 **Breast Cancer**
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
 - 23 **Adolescent Medicine**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
 - 23 **Common Pediatric Orthopedic Problems**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
 - 23 **Special Rounds, Internal Medicine**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 24 **Pediatric Pulmonary Conference**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
 - 24 **Preservation of Ischemic Myocardium**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
 - 28 **Carcinoma of the Cervix**
12 noon-1 p.m. — Overlook Hospital, Summit
(Sponsored by Overlook Hospital and AMNJ)
- Mar.
- 1 **Fluid and Electrolyte Imbalance**
11 a.m. — Greystone Park Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
 - 2 **Infertility**
1 p.m. — Christ Hospital, Jersey City
(Sponsored by AMNJ and AAFP)
 - 2 **Fluid and Electrolyte Imbalance**
11:30 a.m. — Rahway Hospital
(Sponsored by AMNJ and AAFP)
 - 2 **Coagulopathies and Dysproteinemia: Multiple Myeloma and Waldenstroms**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
 - 2 **Child Health**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
 - 2 **Special Rounds, Pediatrics**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 2 **Selected Topics in Gastroenterology**
8-10 p.m. — Valley Hospital, Ridgewood
(Sponsored by N.J. Gastroenterology Society)
 - 2 **Chronic Obstructive Pulmonary Disease**
 - 16 **Acute Renal Failure**
 - 30 **Bedside Diagnosis of Heart Disease**
10:30-12 noon — Passaic General Hospital
(Sponsored by Hahnemann Medical College and AAFP)
 - 2 **Drug Induced Psychosis**
 - 16 **Recent Developments in Mental Health Law**

- 1-2:30 p.m. — New Jersey Medical School, Newark
(Sponsored by CMDNJ and AMNJ)
- 3 **Topics in Neurosurgery**
10 4-5 p.m. — VA Hospital, East Orange
17 (Sponsored by CMDNJ, VA Hospital and AMNJ)
24
31
- 3 **Diagnosis of Rhinitis**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
- 3 **Bypass Grafts**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 4 **Renal Transplantation**
8:30 a.m. — United Hospitals of Newark
(Sponsored by AMNJ and AAFP)
- 4 **Community Psychiatry**
1:30-2:30 p.m. — Trenton Psychiatric Hospital
- 11 **Neuroanatomy and Neuropathology**
2:45-3:45 p.m. — Trenton Psychiatric Hospital
- 18 **Clinical Neurology**
4-5 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital)
- 4 **Hospital Ethics Committee — Pro and Con**
8:30-10 p.m. — Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital, Bergen County Medical Society and AMNJ)
- 7 **Immunology**
8 p.m. — Community Memorial Hospital, Toms River
(Sponsored by AMNJ and AAFP)
- 8 **Cortical Steroid Therapy**
8 p.m. — Paul Kimball Hospital, Lakewood
(Sponsored by AMNJ and AAFP)
- 8 **Clinical Endocrinology**
9 p.m. — Bayonne Hospital
(Sponsored by AMNJ and AAFP)
- 9 **Obstructive Lung Disease**
1:30 p.m. — Runnells Hospital, Berkeley Heights
(Sponsored by AMNJ and AAFP)
- 9 **Current Chemotherapy, Breast Cancer**
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
- 9 **Management of Patients in Diabetic Coma**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
- 9 **Disorders of Biliary Tract and Pancreas**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 9 **Special Rounds, Obstetrics — Gynecology**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 10 **Perennial Allergic Rhinitis, Vasomotor Rhinitis and Serous Otitis Media**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
- 10 **Use and Abuse of Dialysis**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 10- **AAP Spring Meeting**
13 Paradise Island Hotel, Nassau, Bahamas
- 15 **Hematology-Diagnosis of Anemia**
12 noon — St. Mary's Hospital, Orange
(Sponsored by AMNJ and AAFP)
- 16 **Bronchial Asthma**
11:30 a.m.-12:30 p.m. — V.A. Hospital, East Orange
(Sponsored by East Orange V.A. Hospital)
- 16 **Physical Medicine in Office Practice**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 16 **Special Rounds, General Surgery and Specialties**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 16 **Thyroid Diseases**
1 p.m. — Trenton Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
- 16 **Current Advances in Cancer Management**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
- 16 **Forensic Psychiatry**
1-2:30 p.m. — Marlboro Psychiatric Hospital
(Sponsored by Marlboro Psychiatric Hospital and AMNJ)
- 17 **Drug Therapy of Upper Respiratory Allergy**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
- 17 **Family Counseling**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 17 **Management of Angina**
5-6:30 p.m. — Somerset Hospital, Somerville
(Sponsored by Somerset Hospital)
- 18 **Sodium and Potassium Metabolism**
9:10 a.m. — St. Francis Medical Center, Trenton
(Sponsored by Hahnemann Medical College and AMNJ)
- 18 **Headache**
12 noon — Freehold Area Hospital
(Sponsored by AMNJ and AAFP)
- 22 **Echo-Cardiography**
8 p.m. — Warren Hospital, Phillipsburg
(Sponsored by AMNJ and AAFP)

- 22 **Pacemakers**
12 noon — Hospital Center at Orange
(Sponsored by AMNJ and AAFP)
 - 23 **Current Radiation Therapy, Breast Cancer**
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
 - 23 **Arthritis**
11:30 a.m. — Rahway Hospital
(Sponsored by AMNJ and AAFP)
 - 23 **Neurological Diagnosis**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
 - 23 **Special Rounds, Internal Medicine**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 23 **Virology and Interferon**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
 - 24 **Pediatric Pulmonary Conference**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
 - 24 **Marriage Counseling**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
 - 25 **Community Psychiatry**
1:30-2:30 p.m. — Trenton Psychiatric Hospital
Psychology
2:45-3:45 p.m. — Trenton Psychiatric Hospital
Forensic Psychiatry
4-5 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital)
 - 26 **Athletic Injuries**
9 a.m. — Valley Hospital, Ridgewood
(Sponsored by Valley Hospital)
 - 30 **Hepatitis**
3 p.m. — Fair Oaks Hospital, Summit
(Sponsored by AMNJ and AAFP)
 - 30 **Aortic Valvular Disease**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital, and AAFP)
 - 30 **Respiratory Virus Infections**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
 - 31 **Diagnosis and Treatment of Headache**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- Apr.**
- 1 **Community Psychiatry**
1:30-2:30 p.m. — Trenton Psychiatric Hospital
Psychology
2:45-3:45 p.m. — Trenton Psychiatric Hospital
Forensic Psychiatry
4-5 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital)
 - 1 **Proper Use of Antibiotics**
8:30 a.m. — United Hospitals of Newark
(Sponsored by AMNJ and AAFP)
 - 4 **Depression in Adolescent Girl**
8-10 p.m. — 60 Melrose Place, Montclair
(Sponsored by Essex Psychiatric Seminar and AMNJ)
 - 4 **Orthopedic Problems**
8 p.m. — Community Memorial Hospital, Toms River
(Sponsored by AMNJ and AAFP)
 - 5 **Headache**
11 a.m. — Greystone Park Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
 - 6 **Parkinson's Disease and Related Disorders**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
 - 6 **Special Rounds, Pediatrics**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 6 **Selected Topics in Gastroenterology**
8-10 p.m. — St. Michael's Medical Center, Newark
(Sponsored by N.J. Gastroenterology Society)
 - 6 **Chronic Schizophrenia**
1-2:30 p.m. — N.J. Medical School, Newark
(Sponsored by CMDNJ and AMNJ)
 - 7 **Neurosurgical Conferences** - 14 4-5 p.m. — VA Hospital, East Orange
 - 21 (Sponsored by CMDNJ, VA Hospital, East Orange and
 - 28 AMNJ)
 - 7 **Hyperlipedemia**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
 - 12 **Review and Update of OB/GYN**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
 - 12 **Collagen Disease**
8 p.m. — Paul Kimball Hospital, Lakewood
(Sponsored by AMNJ and AAFP)
 - 12 **Echo-Cardiography**
9 p.m. — Bayonne Hospital
(Sponsored by AMNJ and AAFP)
 - 13 **Proper Use of Blood Gases**
1 p.m. — Christ Hospital, Jersey City
(Sponsored by AMNJ and AAFP)
 - 13 **Current Surgical Techniques, Breast Cancer**
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
 - 13 **Headache**
11:30 a.m. — Rahway Hospital
(Sponsored by AMNJ and AAFP)
 - 13 **Cardiac Complications of Antidepressant Drugs and Major Tranquilizers**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)

- 13 **Special Rounds, Obstetrics — Gynecology**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 13 **Therapy of Ambulatory Patients Who Have Had Psychosis**
1-2:30 p.m. — Marlboro Psychiatric Hospital
(Sponsored by Marlboro Psychiatric Hospital and AMNJ)
 - 13 **Update on Collagen Disease**
10:30-12 noon — Passaic General Hospital
(Sponsored by Hahnemann Medical College and AAFP)
 - 14 **Review Symposium — Malpractice**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
 - 14 **Drug Allergy**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
 - 15 **Community Psychiatry**
 - 22 **1:30-2:30 p.m. — Trenton Psychiatric Hospital**
 - Mental Deficiency**
 - 2:45-3:45 p.m. — Trenton Psychiatric Hospital**
 - Forensic Psychiatry**
 - 4-5 p.m. — Trenton Psychiatric Hospital**
(Sponsored by Trenton Psychiatric Hospital)
 - 15 **Scanning**
12 noon — Freehold Area Hospital
(Sponsored by AMNJ and AAFP)
 - 17 **Seminar in Medical Humanism**
8:30-10 p.m. — Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital, Bergen County Medical Society and AMNJ)
 - 19 **Cardiac Arrhythmias**
12 noon — St. Mary's Hospital, Orange
(Sponsored by AMNJ and AAFP)
 - 20 **Child Abuse and Neglect**
1 p.m. — Trenton Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
 - 20 **Pulmonary Pathology in Connective Tissue Disease**
11:30 a.m.-12:30 p.m. — V.A. Hospital, East Orange
(Sponsored by V.A. Hospital, East Orange)
 - 20 **New Cardiac Drugs**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
 - 20 **Special Rounds, General Surgery and Specialties**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 20 **New Frontiers in Psychiatry**
1-2:30 p.m. — N.J. Medical School, Newark
(Sponsored by CMDNJ and AMNJ)
 - 21 **Insect Allergy**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
 - 21 **Carcinoma of Lung**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
 - 21 **Diagnostic Approaches to the Ischemic Lower Extremity**
5-6:30 p.m. — Somerset Hospital, Somerville
(Sponsored by Somerset Hospital)
 - 26 **Endotoxic Shock**
12 noon — Hospital Center at Orange
(Sponsored by AMNJ and AAFP)
 - 26 **Gastrointestinal Bleeding**
8 p.m. — Warren Hospital, Phillipsburg
(Sponsored by AMNJ and AAFP)
 - 27 **Emotional Crises in Practice**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
 - 27 **Special Rounds, Internal Medicine**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 27 **Neonatal Infections**
10:30 a.m.-12 noon — Passaic General Hospital
(Sponsored by Hahnemann Medical College and AAFP)
 - 27 **Lung Cancer**
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
 - 28 **Pediatric Pulmonary Conference and Case Presentations**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
 - 28 **Use and Abuse of Diuretics**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- May
- 2 **Emergency Medicine**
8 p.m. — Community Memorial Hospital, Toms River
(Sponsored by AMNJ and AAFP)
 - 2 **A Learning-Disabled Adolescent**
8-10 p.m. — 1046 South Orange Avenue, Short Hills
(Sponsored by Essex Psychiatric Seminar and AMNJ)
 - 3 **Cerebral-Vascular Disease**
11 a.m. — Greystone Park Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
 - 4 **Thanatology**
1 p.m. — Christ Hospital, Jersey City
(Sponsored by AMNJ and AAFP)
 - 4 **Sports Medicine**
11:30 a.m. — Rahway Hospital
(Sponsored by AMNJ and AAFP)
 - 4 **Low Back Pain**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)

- 4 **Special Rounds, Pediatrics**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 4 **Psychiatric Rehabilitation**
1-2:30 p.m. — N.J. Medical School, Newark
(Sponsored by CMDNJ and AMNJ)
- 5 **Neurosurgical Conferences**
12 4-5 p.m. — VA Hospital, East Orange
19 (Sponsored by CMDNJ, VA Hospital, East Orange,
26 and AMNJ)
- 5 **Veterinary Allergy**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
- 5 **Fluid and Electrolyte Balance**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 5 **Seminar in Medical Humanism**
8:30-10 p.m. — Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital, Bergen County Medical Society, and AMNJ)
- 6 **Proper Use of Blood Gases**
8:30 a.m. — United Hospitals of Newark
(Sponsored by AMNJ and AAFP)
- 10 **Leukemia**
8 p.m. — Paul Kimball Hospital, Lakewood
(Sponsored by AMNJ and AAFP)
- 10 **Plastic Surgery**
9 p.m. — Bayonne Hospital
(Sponsored by AMNJ and AAFP)
- 11 **Thanatology**
1:30 p.m. — Runnells Hospital, Berkeley Heights
(Sponsored by AMNJ and AAFP)
- 11 **Obstructive Lung Disease**
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
- 11 **Sputum Examination**
11:30 a.m.-12:30 p.m. — V.A. Hospital, East Orange
(Sponsored by East Orange V.A. Hospital)
- 11 **Patient with Advanced Cancer**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 11 **Special Rounds, Obstetrics — Gynecology**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 11 **Role of the Therapist in Psychotherapy**
18 1-2:30 p.m. — Marlboro Psychiatric Hospital
(Sponsored by Marlboro Psychiatric Hospital and AMNJ)
- 11 **Clinical Shock**
10:30-12 noon — Passaic General Hospital
(Sponsored by Hahnemann Medical College and AAFP)
- 12 **Urticaria and Angioedema**
11 a.m.-12 noon — United Hospitals of Newark,
(Sponsored by Children's Hospital of Newark and CMDNJ)
- 12 **Immunology and Asthma**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 14- **MSNJ Annual Meeting**
17 Haddon Hall, Atlantic City
- 16 **Diagnosis and Management of Non-Hodgkins Lymphoma**
12 noon-1 p.m. — Overlook Hospital, Summit
(Sponsored by Overlook Hospital and AMNJ)
- 17 **Tuberculosis**
12 noon — St. Mary's Hospital, Orange
(Sponsored by AMNJ and AAFP)
- 18 **What's New in Office Gynecology?**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 18 **Special Rounds, General Surgery and Specialties**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 18 **Pharmacology of Sleep**
1-2:30 p.m. — N.J. Medical School, Newark
(Sponsored by CMDNJ and AMNJ)
- 19 **Atopic Dermatitis**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
- 19 **Outpatient Management of Pulmonary Tuberculosis**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 19 **Cellular Engineering in Medicine**
5-6:30 p.m. — Somerset Hospital, Somerville
(Sponsored by Somerset Hospital)
- 20 **Diabetes**
12 noon — Freehold Area Hospital
(Sponsored by AMNJ and AAFP)
- 20 **Duodenal-Pancreatico Catheterization**
9-10 a.m. — St. Francis Hospital, Trenton
(Sponsored by Hahnemann Medical College and AAFP)
- 24 **Thanatology**
12 noon — Hospital Center at Orange
(Sponsored by AMNJ and AAFP)
- 24 **Bleeding Diseases**
8 p.m. — Warren Hospital, Phillipsburg
(Sponsored by AMNJ and AAFP)
- 25 **Proper Use of Blood Gases**
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)

- 25 Headache**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 25 Special Rounds, Internal Medicine**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 25 Pneumonia: Viral and Bacterial**
10:30-12 noon — Passaic General Hospital
(Sponsored by Hahnemann Medical College and AAFP)
- 26 Pediatric Pulmonary Conference and Case Presentations**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
- 26 Preventative Measures in Heart Disease**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- June**
- 1 T.B. — Outpatient Treatment**
1 p.m. — Christ Hospital, Jersey City
(Sponsored by AMNJ and AAFP)
- 1 Special Rounds, Pediatrics**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 2 Neurosurgical Conferences**
9 4-5 p.m. — VA Hospital, East Orange
(Sponsored by CMDNJ, VA Hospital, East Orange, and AMNJ)
- 16 and AMNJ**
- 30**
- 2 Pulmonary Function Tests**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 3 Psychiatry-Medical Surgical Emergencies**
8:30 a.m. — United Hospitals of Newark
(Sponsored by AMNJ and AAFP)
- 6 Non-Specific Urethritis**
8 p.m. — Community Memorial Hospital, Toms River
(Sponsored by AMNJ and AAFP)
- 7 Arthritis**
11 a.m. — Greystone Park Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
- 8 Special Rounds, Obstetrics — Gynecology**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 8 Endotoxic Shock**
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
- 8 Management of Arrhythmias**
10:30-12 noon — Passaic General Hospital
(Sponsored by Hahnemann Medical College and AAFP)
- 9 Proper Use of Blood Gas**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 14 Endocrine Changes in Menopause**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 14 Pacemakers**
8 p.m. — Paul Kimball Hospital, Lakewood
(Sponsored by AMNJ and AAFP)
- 14 Allergy**
9 p.m. — Bayonne Hospital
(Sponsored by AMNJ and AAFP)
- 15 Adult Respiratory Distress Syndrome**
11:30 a.m.-12:30 p.m. — V.A. Hospital, East Orange
(Sponsored by East Orange V.A. Hospital)
- 15 Special Rounds, General Surgery and Specialties**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 15 Transcultural Psychiatry**
1-2:30 p.m. — New Jersey Medical School, Newark
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- 16 Duodenal Ulcer Disease**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
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- 16 Current Concepts of Addiction**
5-6:30 p.m. — Somerset Hospital, Somerville
(Sponsored by Somerset Hospital)
- 17 Thyroid Diseases**
12 noon — Freehold Area Hospital
(Sponsored by AMNJ and AAFP)
- 21 Hypertension**
12 noon — St. Mary's Hospital, Orange
(Sponsored by AMNJ and AAFP)
- 22 Arterial Blood Gases**
10:30-12 noon — Passaic General Hospital
(Sponsored by Hahnemann Medical College and AAFP)
- 22 Hemorrhagic Shock**
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
- 22 Special Rounds, Internal Medicine**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 23 Psychosomia — A Medical Diagnosis**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 28 Outpatient Management of T.B.**
8 p.m. — Warren Hospital, Phillipsburg
(Sponsored by AMNJ and AAFP)

OBITUARIES

Dr. Charles Butcher

At the grand age of 92, Charles Butcher, M.D., a member of our Cumberland County component, died on August 29. Born in Heislerville, he was the fourth generation of his family to practice medicine there. Dr. Butcher was graduated from Jefferson Medical College in 1909 and following internship he began general practice in 1911 in his home community. He was a past-president of the Cumberland County Medical Society and had been president of the local chapter of the New Jersey Tuberculosis Association for twenty years. He was also active in civic affairs and service organizations, having served a term as president of the local Rotary Club. Dr. Butcher had been on the staff at the Millville Hospital.

Dr. Joseph D. Gatti

One of Bergen County's senior practitioners, Joseph D. Gatti, M.D., of Hackensack, died on August 10. Born in 1909 and graduated from Long Island University Medical School in 1935, Dr. Gatti pursued a career in general surgery and was a Fellow of the American College of Surgeons. He also held Fellowship in the International College of Surgeons and was a member of the prestigious New Jersey Society of Surgeons. He had been on the attending surgical staff at Holy Name Hospital in Teaneck and at Bergen Pines County Hospital in Paramus.

Dr. Gerhard R. Hirschfeld

Word has been received of the death on August 19 of Gerhard R. Hirschfeld, M.D., of Glen Rock. A well known Passaic County psychiatrist, Dr. Hirschfeld was born in 1913, received his medical degree from the University of Bern in Switzerland, and pursued graduate studies in psychiatry, becoming board certified in that specialty. He was a Fellow of the American College of Physicians and of the American Psychiatric Association, and held membership in the Academy of Medicine of New Jersey and the New Jersey Neuropsychiatric Society. Dr. Hirschfeld was chief psy-

chiatrist at St. Joseph's Hospital in Paterson and on the staff in the department of psychiatry at the Valley Hospital in Ridgewood.

Dr. Morvyth McQueen-Williams

Morvyth McQueen-Williams, M.D., a member of our Hudson County component, died on September 15 after a long illness. A native of Berkeley, California, Dr. McQueen-Williams received her medical degree from Yale Medical School in 1939 and took graduate work in radiology at Johns Hopkins University Medical Center, becoming board certified in that specialty. She remained there as assistant radiologist at the Johns Hopkins Hospital and as a member of the faculty at the Johns Hopkins University Medical School. In 1959 Dr. McQueen-Williams moved to Bergen County and opened offices for the private practice of radiology in both Englewood and Hackensack. She had been on the staff at the Jersey City Medical Center and was the author of several scientific papers published in the *American Journal of Physiology* and the *Journal of Experimental Medicine*.

Dr. Rade R. Musulin

Rade R. Musulin, M.D., a member of our Burlington County Medical Society and a practicing physician in Marlton, died on August 27. Born in 1911 in Johnstown, Pennsylvania, Dr. Musulin first pursued a career in law and was admitted to the Allegheny County Bar. He subsequently matriculated at Georgetown University School of Medicine from which he received his medical degree in 1943. Following graduation he served two years in the Medical Department of the U.S. Army and came to Camden County to practice general medicine in 1950. In 1969 he moved his office to Marlton and ultimately transferred his membership to the Burlington component society.

Dr. Adolf S. Rost

At the grand age of 94, Adolf S. Rost, M.D., died on August 15. Born in Berlin (Germany), Dr. Rost earned his medical degree from the University of Berlin in 1907. He emigrated to the United States in the late 1930's and began to practice general medicine in Orange in 1939. He had been on the staff at the East Orange General

and Montclair Community hospitals before retirement in 1960. Dr. Rost was a member of our Essex County component and resided in Montclair.

Dr. Michael W. Silver

One of Passaic County's senior practitioners, Michael W. Silver, M.D., of Paterson, died at his home on September 1. A native of Paterson, Dr. Silver earned his medical degree from the University of Minnesota Medical School in 1938. He was an internist and had staff appointments in that department at Barnert Memorial and Paterson General Hospitals. He had also trained as a pathologist, with special emphasis on hematology, at Ohio State University and was a member of the American Society of Clinical Pathologists and its New Jersey affiliate. Dr. Silver served in the Medical Department of the U.S. Army during World War II. He was 69 years old at the time of his death.

Dr. William M. Sweeney

On September 6, at the untimely age of 55, William M. Sweeney, M.D., of Montvale in Bergen County, died after a long illness. Dr. Sweeney was graduated from St. Louis Univer-

sity School of Medicine in 1947, where he also took a three-year residency in internal medicine. He practiced briefly in St. Louis, and then accepted a position as medical researcher with Lederle Laboratories in Pearl River, New York. In 1960 he came to New Jersey to establish a private practice. Dr. Sweeney was on the medical staff and was also director of the nuclear medicine laboratory at Bergen Pines County Hospital in Paramus. He had served his country in the Medical Department of the U.S. Army during the Korean conflict.

Dr. Anthony A. Virgilio

One of Essex County's senior practitioners, Anthony A. Virgilio, M.D., died on August 11. Born in 1906, and graduated from Georgetown University School of Medicine in 1934, Dr. Virgilio practiced general medicine in his home town of Orange for many years. He was active in community affairs and at one time had served as public safety director and as city physician. Dr. Virgilio had staff appointments at St. Mary's Hospital in Orange as well as Orange Memorial and East Orange General hospitals. During World War II he had served with the Medical Department of the U.S. Army.

BOOK REVIEW

Medical Statistics in World War II. Office of the Surgeon General of the Army. Medical Department, U.S. Army, Washington D.C., 1975. (\$19.50)

This massive historical work, published 30 years after the close of World War II, documents medical data relating to the largest concentration of combat troops ever mobilized by the United States. The data not only relate to battle casualties, but to non-battle disease and non-battle injuries in a combat force deployed in eight diverse terrestrial theaters of desert, mountain, jungle, and frigid Iceland. The document serves also as a landmark to the foresight, the methodology, and the technology and perseverance which have resulted in the analyses of over 18 million individual medical records.

The document details the basis of the 4.5 percent case fatality rate among wounded based on the Adjutant General's report of "Army Battle Casualties and Non-Battle Deaths in World War II."

During the four-year period (1942-1945) of World War II, there were 306,230 deaths. The annual death rate among U.S. Army personnel was 12.1 per 1000 average strength per

year. Seventy-five percent of deaths were battle deaths. The battle death rate of World War II was but 56 percent of the World War I rate. The death rate for disease in World War II was less than 4 percent of the World War I rate and the World War II death rate for non-battle injuries was almost double the World War I rate; probably due in large part to the mechanized and automotive equipment of World War II. Non-battle injury accounted for the highest non-effective rate of 5.77 per day per 1000 average strength. Infections and parasitic disease at a rate of 5.24 and respiratory disease at 4.20 per day ranked second and fourth in non-effective rates. Neuropsychiatric and mental disease had a non-effective rate of 4.44 and ranked second.

The data contained in this document reflect grossly on the extent of demand made upon the medical services of the U.S. Army in World War II. They are refined in precise detail by theater of operation and by effect upon the strength of the forces involved. These services were based on a small cadre of professional officers and expanded through a massive effort of civilian medicine to meet the needs of the United States in time of crises.

As a reference text of historical and logistic significance, the volume is an unparalleled document. Its current value, however, is reduced insofar as the practical lessons learned have led to advances in military medicine beyond the scope of imagination in 1941. The helicopter, vascular surgery, monitoring, and life support systems are now highly refined and relegate the document truly to history.

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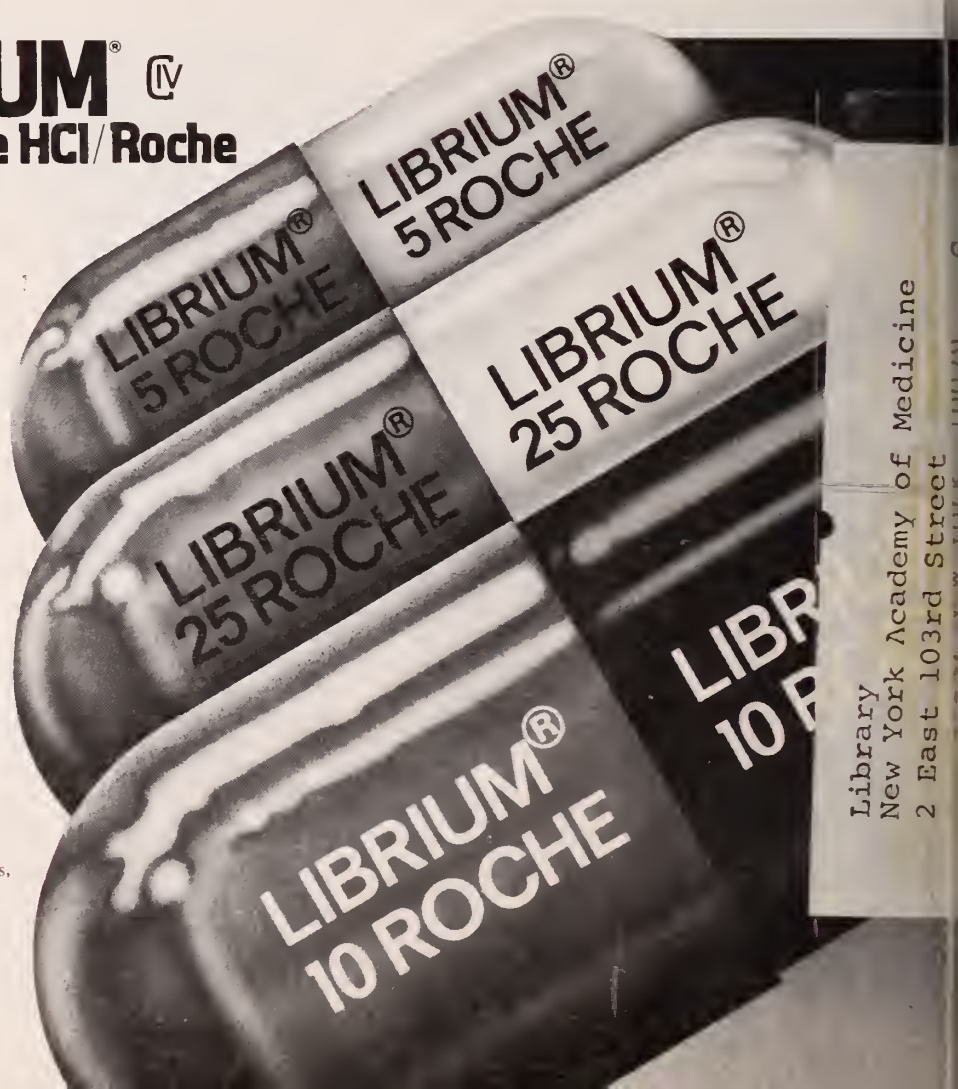
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Published monthly (since 1904), under direction of the Committee on Publication, by The Medical Society of New Jersey, 315 West State St., Trenton, N.J. Printed in Hanover, New Hampshire by the Dartmouth Printing Co. Whole number of issues 868. Member's subscription (\$5) is included in Society dues. Rates for nonmembers, \$10; outside USA add \$4 for postage. Single copies, \$1. Address communications to *The Journal*, MSNJ, P.O. Box 904, Trenton, N.J. 08605 (609) 394-3154. Second class postage paid at Trenton, N.J. and additional entry office. Copyright 1976 by The Medical Society of New Jersey.

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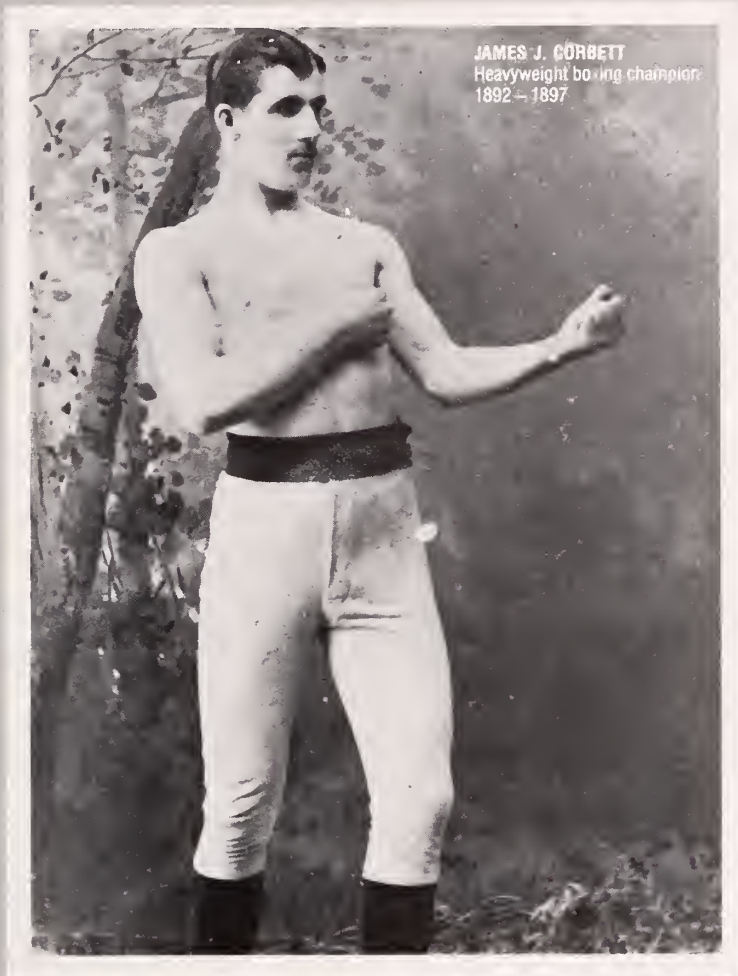
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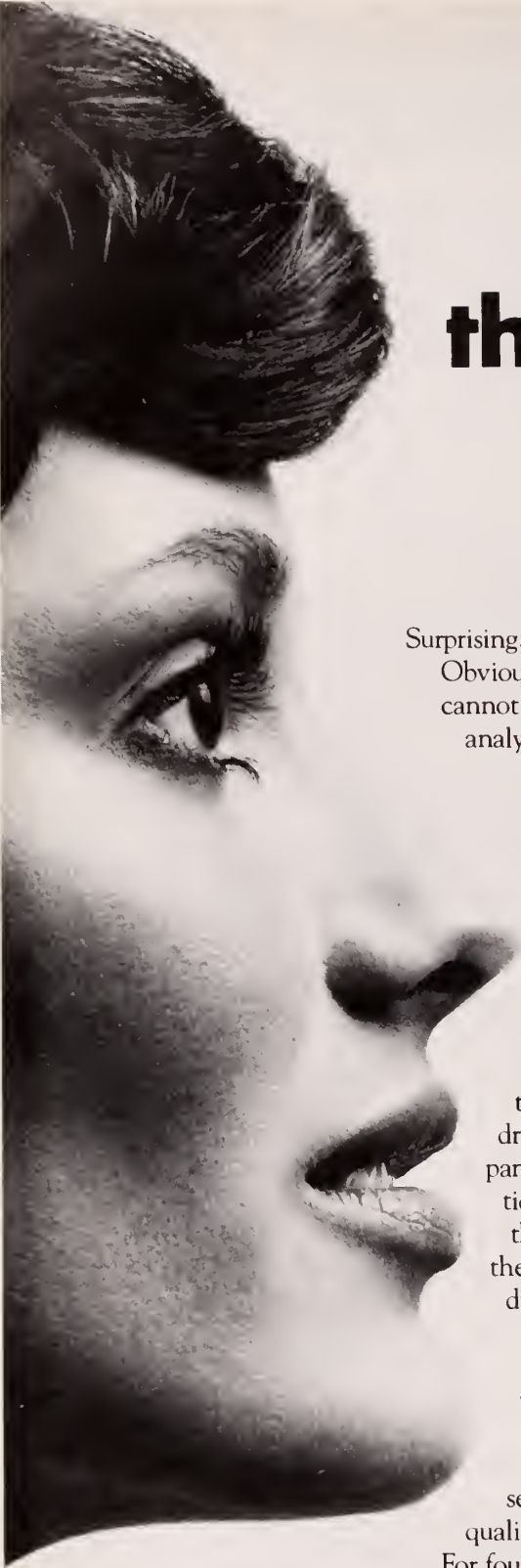


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Season's Greetings

The holiday season marks the end of America's Bicentennial and the New Year proclaims the beginning of our third century. On this momentous occasion the Publication Committee and the staff of *The Journal* extend season's greetings to our readers. May you all enjoy a healthy, happy, and unfettered 1977. A.K.

Except the Medicaid Billing Clerk

Each graduate of medical school recites and accepts the Hippocratic oath, an ethical guide of the medical profession. Among the promises appears the following:

"All that may come to my knowledge in the exercise of my profession or outside my profession or in daily commerce with men, which ought not to be spread abroad, I will keep secret and will never reveal."

The latest version of the New Jersey Medicaid Manual for physicians contains requirements which now interpose this governmental agency between the physician and his oath and the private knowledge he may gain about his patient. J. Charles Breme, M.D., Medicaid Medical Director, informed New Jersey physicians that "the revised edition of the (New Jersey Medicaid) manual states that claims submitted for consultation performed in the *office* or *home setting* must be accompanied by a copy of the report furnished to the referring physician."

Thus, the revised Hippocratic oath should end: "I will keep secret and will never reveal — except to the Medicaid billing clerk." Of course, the billing clerk is free to share this information with any of her friends since she doesn't take any oath at all!

Poor Hippocrates! How naive you were! You forgot that politicians take an oath to a different god and worship power and votes rather than ethical conduct. A.K.

Some politicians, consumer-advocates, health professionals, and assorted "do-gooders," pushing America toward National Health Insurance (NHI), like to speak about the inability of the "underprivileged citizens" to obtain adequate health care under our present system. The implication is that NHI will solve the medical (and many other) problems of all, but especially "the poor." Were this premise based on naivete, one could be more tolerant. The truth is that the espousers of this "line" easily could envision the truth of the problem and the complexity of its solution, if they chose to do so. Evidence such as the following would help.

In a recent study, a group of poorly controlled diabetic children and their families were evaluated to discover the reasons for the poor control. Some of the findings and conclusions were as follows:

1. Poor emotional and physical health among these diabetic children was correlated with disturbed family life.
2. These families had emotional difficulties, individual psychiatric problems, and marital schisms.
3. Anger, rejection, and guilt characterized such households.
4. The fathers were passive, helpless, inadequate men who had poor self-esteem and who did not participate in the upbringing and discipline of their children. Alcoholism was often a problem.
5. The mothers were depressed, narrow women who had limited contacts outside the nuclear family and who struggled with family-rearing in a situation of personal, economic, social, cultural, and educational deprivation.
6. In these disturbed families, physicians and other health professionals exerted little influence on their health care. The presence of chronic disease was only one more problem in a life full of problems.

Such a study tells us that many underprivileged families of this type have a universal deprivation which will not be solved by NHI or any other single approach. The lack of organized personalities in the parents and children alike antedate their health problems. Their inability to cope with life's demands tends to relegate such families to second-class citizenship — not a poor system of health, education, or welfare benefits. Like the fabled horse who will not drink when led to water, such families do not take advantage

of *free* education, *free* libraries, *free* museums, or *free* concerts. They *do not* seek out *free* job training. They are unwilling to change life styles for their own good. They *do* accept welfare checks, food stamps, and a modicum of crisis health care in emergency rooms. They *do not* evoke sustained interest in preventive health measures.

Will NHI change such family structures? Will it solve the co-mingled web of personality, physical, emotional, and environmental distortions enough to make an impact? Not likely! It will take massive social, mental health, and interpersonal rehabilitation over many decades. It is not a disgrace to be poor and underprivileged. *It is* a disgrace to *use* the poor as a stepping stone to political power. The purveyors of simple solutions to complex problems are attempting to do just that — even at the risk of destruction of a good health system. Although the question of NHI realistically may be *when* rather than *if* it will appear, our patients should be on notice that one never gets something for nothing. NHI will be expensive, not free health care. A.K.

Television Up, Reading Down, SAT Down

Educators throughout the United States are concerned about the declining SSAT and SAT scores of our children and have spent untold hours in discussion, evaluation, and interpretation of the Educational Testing Service data. Students, parents, educational psychologists, college admission officers, and teachers each have a pet theory. One common explanation of educators as to the decline in the verbal SAT scores is television. Experts equate excessive television viewing with reduced reading. The end-result is decreased vocabulary, stunted reading ability, and lower verbal SAT scores.

The selective use of television for entertainment

and education cannot be faulted, so long as it is selective. Television has become the baby-sitter for America's toddlers and youngsters, as well as the residents of nursing homes. It helps convalescent hospitalized patients pass the hours, although physicians on rounds often find their patients asleep with the speaker in hand. Closed circuit video viewing is being used in some hospitals as a means of patient education.

Not surprisingly, however, evidence is beginning to appear which strongly suggests that the overwhelming volume of television exposure to violence does indeed promote aggressive, antisocial behavior in children during their most impressionable years. On the other hand, there is also some evidence that appropriate use of video time — such as the *Sesame Street* approach — may enhance vocabulary, reading interest, and ability. Will the "graduates" of *Sesame Street* ultimately raise America's verbal SAT scores? It is too early to tell, but the possibilities are positive enough to warrant some hope and encouragement.

Physicians — especially those who treat children and adolescents — have a prime responsibility to impress their patients and their patients' parents with the importance of controlled television viewing, enhanced reading time, and the use of other techniques for improving verbal skills. This is especially true of the families from blighted socio-economic backgrounds. High verbal SAT scores are the key to college admission, but they may also be the means of escape from social deprivation and economic slavery for the children of the ghetto.

Instead of attacking the tests (or the testers) it behooves health professionals to attack the problems. In this regard, medicine can make a major contribution to the education of our youth by an awareness of this particular problem. Physicians being perennial readers may positively influence their young patients to do likewise. A.K.

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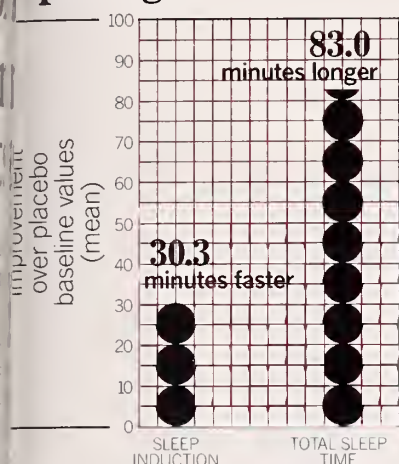
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The ultimate objective test: sleep laboratory proof of effectiveness... now in geriatric insomnia patients

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Before prescribing Dalmane (flurazepam HCl), please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: Several studies of minor tranquilizers (chlordiazepoxide, diazepam, and meprobamate) suggest increased risk of congenital malformations during the first trimester of pregnancy. Dalmane, a benzodiazepine, has not been studied adequately to determine whether it may be associated with such an increased risk. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, limit initial dosage to 15 mg to preclude oversedation, dizziness and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in patients who are severely

depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, paradoxical reactions, e.g., excitement, stimulation and hyperactivity, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase.

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Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

REFERENCES:

1. Frost JD Jr: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ
2. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ
3. Robinson DS, Amidon EL: Interaction of benzodiazepines with warfarin in man, in *The Benzodiazepines*, edited by Garattini S, Mussini E, Randall LO. New York, Raven Press, 1973, p. 641

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ORIGINAL ARTICLES

Recent advances in gastroenteritis include the identification of new etiologies (Rotavirus; Norwalk agent), the demonstration of two main pathogeneses (enterotoxin production and invasion), the understanding that different strains of E. coli are capable of each pathogenetic mechanism, the clarification of diet management (problems of osmolarity and disaccharide absorption) and the concerns that antiperistaltic agents and absorbents may be harmful. These advances are discussed and their implications for the primary care practitioner are stressed.

Acute Infectious Gastroenteritis: Recent Advances Pertinent to Primary Care Practice

Richard H. Rapkin, M.D.
Piscataway*

Acute infectious gastroenteritis is one of the most common acute problems seen by the primary care practitioner. This illness is usually benign and self-limited. Recent advances in understanding the etiology, pathogenesis, and treatment of this syndrome may have made traditional therapeutic modalities outmoded or at least questionable. It is the purpose of this review to call attention to new information, re-emphasize some older data, and thereby update the primary care provider's approach.

Definition

The specific pathologic lesion of gastroenteritis depends upon etiology and, therefore, a general anatomic definition is impossible. The syndrome, acute infectious gastroenteritis, can be defined as an acute process characterized by diarrhea (change of stool to include increased frequency and liquid content) and by other inconsistent signs and symptoms such as vomiting, malaise, abdominal pain, and fever. An exhaustive review of all causes of diarrhea is beyond the scope of this discussion, in which emphasis will be placed upon infectious diseases whose major manifestation is diarrhea.

Etiology

"Parenteral diarrhea" is a time-honored pediatric entity. It is thought that inflammatory disease not localized in the gastrointestinal (GI)

tract may cause diarrhea without direct invasion. The mechanism for this has never been defined and, since the only evidence for its occurrence is uncontrolled empiric observation, it cannot be seriously discussed. The etiologies to be considered herein have satisfied Koch's postulates: the organism constantly is associated with the disease; the organism is isolatable; the disease is reproducible experimentally; the organism is again recoverable from patients or animals with the experimentally-induced disease. They include gastroenteritis caused by ingestion of preformed toxins and gastroenteritis caused by agents entering the GI tract (Table I).

Pathogenesis

The classic studies of the cholera vibrio^{1,2} have demonstrated that these organisms elaborate an exotoxin (called an enterotoxin) capable of causing secretory activity by the small intestine leading to a net fluid and electrolyte flux into the intestinal lumen and hyperperistalsis. The organisms attach to but do not invade the mucosa and there is little or no inflammatory response to their attachment. The enterotoxin has been isolated and will result in the same pathogenesis without the presence of the organism. A similar mechanism has been demonstrated for some members of the species *E. coli*³. Other members of the *E. coli* species

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Table I
Etiologies of Gastroenteritis

- I. Gastroenteritis Caused by Ingestion of Preformed Toxin
 - A. *Staphylococcus aureus*
- II. Gastroenteritis Caused by Organism Entering GI Tract
 - A. Viral
 1. Rotavirus (reovirus, orbivirus, duovirus)
 2. Norwalk agent
 3. Others (Koch's postulates not totally demonstrated)
 - (a) Enteroviruses (Coxsackie, ECHO)
 - (b) Adenovirus
 - B. Bacterial
 1. *E. coli*
 2. *Salmonella*
 3. *Shigella*
 4. *Vibrio cholera*
 5. *Vibrio parahemolyticus*
 6. *Staphylococcus aureus*
 7. *Clostridium perfringens*
 8. Others (Koch's postulates not satisfied)
 - (a) Enterococci
 - (b) *Bacillus cereus*
 - (c) *Providencia*, *Citrobacter*, *Klebsiella*, *Enterobacter*, *Pseudomonas*, *Proteus*.
 - C. Protozoa
 1. *Giardia lamblia*
 2. *Amebae*

may invade the mucosa⁴ but the cholera organism does not seem to at all. Organisms whose mechanism of disease production is cholera-like are called enterotoxigenic (Table II).

On the other hand, *Shigella* organisms appear to cause gastroenteritis by a direct invasion of the mucosa leading to ulceration, necrosis, marked inflammatory changes in the bowel wall, bleeding, and exudation of white cells into the intestinal lumen⁵. *Salmonella* (non-typhoid) organisms also cause disease by invasion although the inflammatory response is less destructive and the damage to the mucosa is less. Bleeding and large numbers of white blood cells in the intestinal lumen are less common in *Salmonellosis*⁵. Some strains of *E. coli* appear to be *Shigella*-*Salmonella*-like in that they also invade the intestinal wall and cause inflammation. These organisms are called enteroinvasive, as distinguished from the enterotoxigenic cholera-like organisms⁶ (Table II).

Other organisms cause gastroenteritis in less well-defined ways. *Giardia* appears to attach to the upper small intestinal mucosa. The viral agents (Rotavirus; Norwalk agent) cause some blunting of the villi of the upper small intestine⁷.

Table II
Pathogenesis of Gastroenteritis

Site of Action	Mechanism of Action		
	Toxigenic (Enterotoxigenic)	Invasive (Enteroinvasive)	Unknown
Small intestine	<i>V. cholera</i> <i>C. perfringens</i> <i>S. aureus</i> <i>E. coli</i>	<i>Salmonella</i> <i>E. coli</i>	<i>Rotavirus</i> Norwalk agent <i>V. parahemolyticus</i> <i>B. cereus</i> <i>Giardia</i>
Large intestine		<i>Shigella</i> <i>Salmonella</i> <i>Ameba</i> <i>E. coli</i> (?) <i>S. aureus</i>	

In addition to these basically disparate pathogenetic mechanisms, the site of the GI tract involved seems to be peculiar for each organism or group⁸ (Table II). The upper small intestine (duodenum) is the probable site of action of *Giardia* and the newer viral agents. Cholera and enterotoxigenic *E. coli* produce their effects on the lower small intestine. *Salmonella* has a preference for the ileum and cecum, while *Shigella* invades the colon and rectum. Etiologic diagnosis may, therefore, be predictable by clinical signs and symptoms.^{9,10}

The various etiologies of gastroenteritis share a common ability: they all affect the absorptive mechanisms of the GI tract. This is probably due in all cases to changes in the microvilli of the small intestinal endothelium. The result of this microvillous damage is the partial loss of the ability to absorb disaccharides, particularly lactose¹¹. Perpetuation of the disease may occur by feeding lactose leading to the subsequent loss of the ability to absorb other disaccharides and even monosaccharides. This is most likely to occur in individuals who are malnourished, especially in the very young. Protracted diarrhea of infancy,¹² in which malabsorption is life-threatening, may result. Despite the fact that these complications are unusual, they have implications for management.

Diagnosis

Much of the time it is not essential to define the etiology since almost all gastroenteritis is acute, benign, and self-limited, but one should be con-

cerned about significant systemic toxicity (suggests invasive organism disease), rapid development of dehydration (cholera-like disease), bloody diarrhea (colitis caused by *Shigella* or *Ameba*) or prolonged malabsorption (acquired lactase intolerance; protracted diarrhea of infancy). Therefore, it is important to assess etiology with each of these clinical findings: toxicity, dehydration, bloody stools and malabsorption.

The Wright's stained stool smear is a simple test which is extremely valuable in practice and may indicate the possibility of an enteroinvasive etiology by the demonstration of many polymorphonuclear leukocytes and red blood cells. Aside from this office test, etiologic information can best be obtained by fresh stool or rectal swab for culture. Most laboratories will be able to isolate *Shigella* or *Salmonella*; if *E. Coli* is isolated, it can be serotyped to see whether it is one of the types that has been associated with gastroenteritis in the past. However, newer information regarding pathogenesis implies that *E. coli* of other types may be enteroinvasive or enterotoxigenic and, therefore, serotyping may

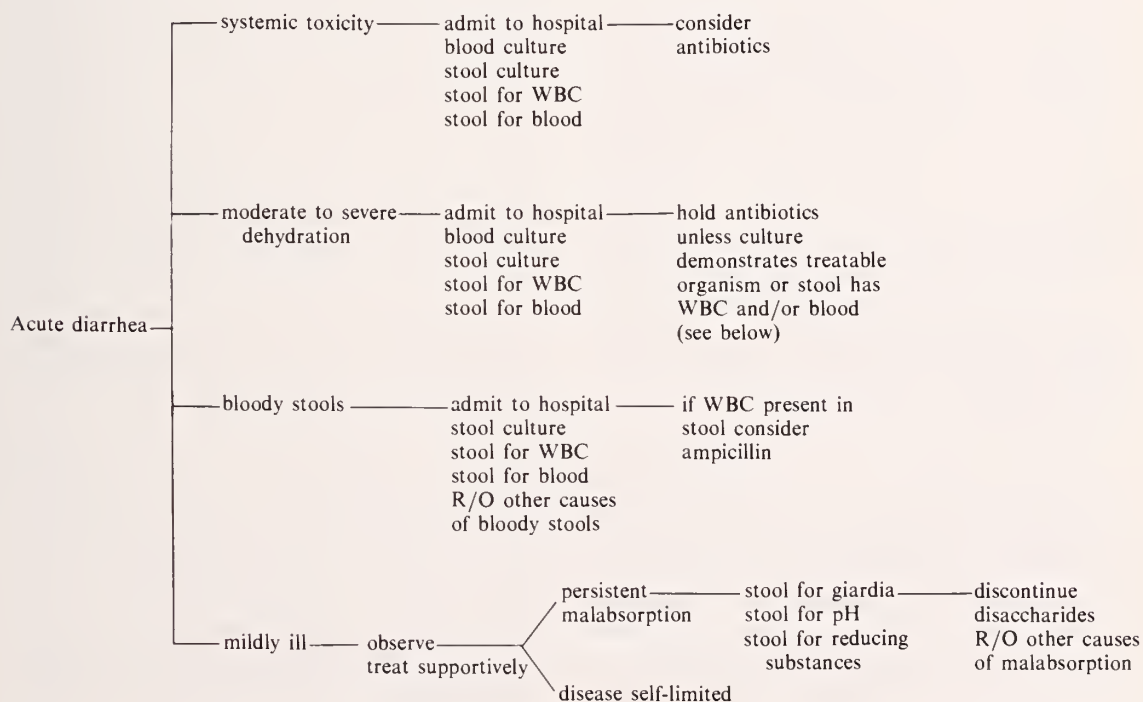
be misleading⁶. "Enteropathogenic" serotypes may not be pathogenic and "nonenteropathogenic" serotypes may indeed be. Bioassay techniques to assess invasiveness (enteroinvasive) or toxin production (enterotoxigenic) are cumbersome and not readily available.

If malabsorption is present, it is wise to examine stool or duodenal aspirates for *Giardia* cysts or trophozoites. One may assess the pH of the stool, which is normally alkaline but becomes acid in disaccharide malabsorption. In addition, reducing substances in the stool by a Benedict's test may indicate the presence of disaccharide malabsorption since normally they are not present. One cannot overemphasize the need for the primary care practitioner to assess etiology in cases of gastroenteritis with systemic toxicity, dehydration, blood in the stools, or malabsorption (Table III).

Differential Diagnosis

Diarrhea, blood in the stool, and malabsorption are associated with many causes, and it is essential carefully to assess them. However, acute

Table III
Specific Management of Gastroenteritis



gastroenteritis is reasonably distinctive so that one can make a clinical determination that there is no underlying illness most of the time. The clinician, however, must beware of two things: the insidious development of chronicity and "mimicry."

Insidious chronicity means the gradual change from acute to chronic disease which may occur under observation. The patient may have a sudden onset of diarrhea which appears to continue for too long a period. Acute infectious gastroenteritis is a short disease which rarely lasts more than a week, so the patient deserves a more extensive evaluation when the duration of illness is protracted.

"Mimicry" refers to the patient with appendicitis, intussusception, or hepatitis who presents in the midst of a seasonal epidemic of gastroenteritis and whose presentation mimics acute infectious gastroenteritis. Each patient needs careful initial assessment, during which one must be always on guard not to overlook subtleties. Since most gastroenteritis is benign and self-limited, the major responsibility of the primary care provider is to be sure that the patient does not have a different disease.

Management: Non-Specific

Most people, lay and professional alike, think that gastroenteritis should be treated with a "light diet" and non-specific antiperistaltic or absorbing agents such as atropine and kaolin-pectin. Recent data call these most basic assumptions into question. What is a light diet? Do agents that slow the bowel or absorb diarrhea water have any value? The answer to the latter question is not completed but these agents may make the illness more severe and longer lasting¹³⁻¹⁵. In addition, standard dietary therapy has some major dangers.

Since lactose malabsorption is apt to be common in all gastroenteritis, milk or milk products have no place in its treatment. If one gives lactose to a lactose malabsorber, the lactose will not be absorbed and, because it is a small osmotically active molecule, it will drag water along with it causing an "osmotic diarrhea." In older children or adults one should suggest

avoidance of milk for a few days. In infants, substitution of a non-lactose containing formula (e.g. Nutramigen®) may be wise for approximately one week.

The fluids given should have low osmolality, some sucrose or glucose for energy of metabolism (and to minimize fat utilization and ketosis), and some sodium and potassium. The dangers of hyperosmolar dehydration, especially in infants, causing cerebral bleeding and severe brain damage are significant and must be guarded against¹⁶. The use of boiled skim milk is exceedingly dangerous. Whole cow's milk has an osmolality of 255 milliosmoles per kilogram and provides little if any free water. Boiled skim milk has a much higher osmolar load (as much as 600 milliosmoles per kilogram) which the dehydrated patient may be unable to excrete.

Some electrolytes are needed, however, especially in cholera-like gastroenteritis or toxigenic *E. coli* disease where gastrointestinal fluid and electrolyte losses may be so great as to lead to shock from extracellular fluid depletion. These extremely large losses which are rare in the United States are best dealt with by parenteral fluid replacement in the hospital. In most cases of gastroenteritis in our country, the most practical oral fluids are a variety of juices and sugar-containing commercial liquids such as sodas, High C®, and Kool Aid®. These contain small quantities of sodium and are usually sterile. Commercial or homemade electrolyte mixes are often too highly osmolar and may be dangerous when carelessly made or used. After the initial rehydration period, a gradual return to normal diet is indicated with milk given last. The avoidance of fat has no basis in fact. Initially, fat may not be well absorbed, but it will do no harm since it is not osmotically active. Subsequently, it is a rich source of calories for re-establishment of adequate nutrition.

Recently there have been several studies on the value of atropine, opium, kaolin, and pectin for the treatment of Shigellosis and non-specific gastroenteritis¹³⁻¹⁵. The Shigellosis study demonstrated a prolongation of illness from use of these agents; the other studies demonstrated neither harm nor value. A theoretical explanation suggests that diarrhea may be the normal

response of the gastrointestinal tract to rid itself of a noxious agent; anything which slows that response may intensify or may prolong the effects of the noxious agent.

In pediatric practice, there has been traditional resistance to use of these agents. Kaolin and pectin make it difficult for the pediatric practitioner to assess the frequency and liquidity of the stool, a valuable clinical clue to deterioration. Some agents containing atropine and opium have had severe side effects in infants. For these reasons the primary care practitioner should be cautious in his use of these agents in all his patients and especially in children.

Management of Specific Agents

C. perfringens, which has been associated with food poisoning, usually is self-limited and requires no specific therapy other than fluid support.

E. coli can be either enterotoxigenic or enteroinvasive. No well-controlled studies have demonstrated whether antibiotic therapy is essential. In epidemic diarrhea of small infants caused by *E. coli*, the use of oral neomycin or colistin appears to shorten the illness. In "turista" (travel-associated diarrhea frequently caused by *E. coli*) antibiotic therapy appears to be of little value¹⁵. When sepsis is suspected, an appropriate parenteral antibiotic such as kanamycin or gentamicin is essential.

Giardia lamblia has caused epidemics of mild but prolonged gastroenteritis. Its association with ski resorts (Aspen, Stowe) or cold weather (Leningrad) is novel. Treatment with quinacrine or metronidazole is effective.

The *Norwalk agent*¹⁷ is a new, unclassified virus, which has been seen by electron microscopic examination of the stools of children and adults with non-specific gastroenteritis. The etiology has been established by the feeding of bacteria-free filtrates of such particle-containing stools to volunteers; the identical disease has been produced and the particles have again been found in the stool. Treatment is symptomatic.

*Rotavirus*¹⁸ is another unclassified viral agent, which is found in the stools of infants and very

young children and which appears to be the cause of a large proportion of gastroenteritis in this age group. This agent, which is also called duovirus or orbivirus, is probably a reovirus. There is no specific treatment.

Salmonella (non-typhoidal) gastroenteritis may be associated with sepsis, meningitis, or metastatic disease. When such complications are suspected, appropriate cultures should be obtained and vigorous treatment instituted with ampicillin or chloramphenicol depending upon antibiotic sensitivity. The morbidity of uncomplicated salmonella gastroenteritis is increased and the carrier state prolonged when antibiotics are administered. Therefore, uncomplicated salmonella gastroenteritis should not be treated with antibiotics.¹⁹

Shigella species usually cause a fulminant colitis with major systemic toxicity, yet they are rarely isolated from the blood and the disease is usually self-limited. The course can be shortened by the use of an appropriate antibiotic (ampicillin, cotrimoxazole) but, wherever these antibiotics have been used widely, shigella-resistance has developed. One must weigh the value to the individual of shortening his illness versus the disadvantage to the community of such resistance. When resistant shigella cause disease (e.g., in the compromised host) they may be difficult to treat. Shigellosis can be treated symptomatically in the majority of previously vigorous individuals.

Staphylococcus aureus causes a self-limited food poisoning syndrome by elaborating a toxin. Treatment is usually supportive.

Vibrio cholera is not seen in the United States. It produces diarrhea by elaborating an exotoxin. Although antibiotic therapy is not essential, the disease is shortened and contagion is altered by tetracycline.

Vibrio parahaemolyticus is associated with food poisoning, especially by shellfish. It produces a toxin and is best treated supportively.

The management of acute gastroenteritis can be summarized by Table III.

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Lifemobile Project

Equipment for the Lifemobile Project in Mercer County (founded by the Mercer County Heart Association) shortly will be installed in each of the five hospitals in Mercer County and in the first ambulance that will be operational as a Lifemobile by the end of the year in Trenton. Further funding will make it possible to outfit additional Lifemobiles to bring advanced health care capabilities to the area's townships, and ultimately to the entire county. The goal is \$300,000.

Participating hospitals are Hamilton, Helene Fuld Medical Center, The Medical Center at Princeton, Mercer Medical Center, and St. Francis Medical Center. The project director is Dr. L. Barry Ultan, a cardiologist on the staff at Helene Fuld; coordinator is Mr. Jerry Stein.

Lifemobiles, also known as Mobile Intensive Care Units, are designed to enable trained paramedics to begin definitive emergency care at the scene of an accident or cardiac incident. Special equipment enables them to transmit electrocardiograph rhythm strip data and other essential information back to the hospital by telemetry and radio voice communication, for analysis by the physician who directs on-the-spot treatment. In this way, the patient can be stabilized by the time he arrives at the hospital.

To date three paramedics from Mercer County have completed their training and are about to be certified by the New Jersey Board of Medical Examiners. Four more trainees are expected to be certified by the end of the year; an additional 33 students are now in preparation.

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The optimum conservative management of chronic renal insufficiency and renal failure includes correction of reversible factors affecting renal function; assessment of renal function with adjustment in diet, sodium and water intake, and medication; control of blood pressure; maintenance of nutrition; and control of secondary hyperparathyroidism and osteodystrophy.

Office Management of the Failing Kidney*

John F. Mele, M.D., Asbury Park

The optimum conservative management of chronic renal failure is the correction of reversible factors affecting renal function. There should be periodic assessment of renal function and end-organ effects with appropriate adjustment in: (1) maintenance of optimum nutrition via diet, sodium and water intake, and supplementary medications; (2) control of blood pressure to minimize vascular disease; and (3) control of secondary hyperparathyroidism and renal osteodystrophy.

As the underlying renal disease progresses conservative management will not suffice, for the associated medical complications will affect the patient's ability to tolerate severe renal insufficiency. This will then necessitate chronic hemodialysis and/or transplantation. The conservative management of patients with chronic renal insufficiency has become increasingly important with the addition of these two modalities to the physician's armamentarium, but the patient's medical and emotional status at the time therapy is initiated directly influence morbidity and mortality.¹

Chronic Renal Failure

The manifestations of chronic renal failure include fluid overload, hypertension, and anemia which are common findings and are present when there is a mild to moderate state of renal insufficiency. Weakness, anorexia, nausea, and vomiting generally occur when the glomerular filtration rate (GFR)** falls below 15 ml per minute while neurological symptoms of impaired sensory function, disorientation, and muscle twitching usually manifest themselves when severe renal failure ensues (a GFR of 10 ml per minute or less).

The patient's *history* may point to the type of renal disease and the rate of its progression and may allow one to predict his ultimate prognosis.

Diseases which primarily involve the medulla and interstitium, such as polycystic kidney disease, chronic pyelonephritis, interstitial nephritis, and analgesic nephritis generally are well tolerated with progressive dysfunction over a long period of time. Patients afflicted with nephrosclerosis, glomerular sclerosis, membranous nephropathy, and collagenous nephropathies, however, tolerate their diseases poorly and rapidly progress to end-stage renal failure.

It is of the utmost importance to discover factors and events which point to a reversible type of renal failure. A rapid decline in renal function over days to weeks is highly suggestive of a reversible cause. Conversely, a long protracted course involving years suggests an irreversible deterioration of renal function.

Symptoms of obstruction such as flank pain, frequency, urgency, dysuria, nocturia, decreased stream force and, ultimately, incomplete bladder emptying are highly suggestive of a potentially reversible problem. At times, the patient, such as the diabetic with neuropathy, may be asymptomatic. Such patients may present only bacteriuria, pyuria, and deteriorating renal function. Improvement in function may follow proper therapy, however, the presence of

*Read before the Sections on Anesthesiology and Medicine, 209th Annual Meeting, The Medical Society of New Jersey, June 1, 1975, Cherry Hill. Dr. Mele is chief of the Section on Nephrology and Hemodialysis, Jersey Shore Medical Center, Neptune.

**Urine formation begins with the production of large quantities of an ultrafiltrate of plasma at the glomerulus. Normally 20 percent of the plasma traversing the glomerulus is expressed from the blood as a protein-free ultrafiltrate in which the concentration of low-molecular weight substances is equal to their concentration in plasma water. The rate at which the kidneys form this ultrafiltrate is termed the GFR. Normal rate is 120 ml/minute or 180 L/day, which can be measured by application of a clearance technique. This requires a substance such as inulin which passes freely into the glomerular ultrafiltrate but is neither removed from nor secreted into the urine by the renal tubule. Thus, the renal clearance of insulin is a measure of the GFR.

obstruction markedly limits complete eradication of the infection.

Abrupt changes in fluid and electrolyte balance, as seen occasionally in gastroenteritis, indicate a reversible type of renal insufficiency. Functional impairment of renal perfusion as may occur in severe dehydration or circulatory collapse, should be excluded. Nephrotoxic agents used should be evaluated because of their effects upon the kidney as well as the liver. Prolonged surgical procedures, massive trauma, and diagnostic studies, particularly of the urinary tract, should be considered as possible factors in precipitating abrupt, reversible deterioration of renal function.

The *physical examination* can reveal the end-organ effects of renal insufficiency with both therapeutic and prognostic implications. The blood pressure in the supine and upright positions is usually elevated, while orthostatic hypotension is suggestive of volume depletion, the visceral neuropathy of diabetes mellitus, amyloidosis, and the use of antihypertensive therapy. Funduscopic examination may reveal vascular changes of hypertension or diabetes. The patient's skin is usually sallow in color due to the urochrome deposits and anemia, while a decrease in skin turgor, scaliness, and ecchymotic changes are also common.

The presence of hypertension, neck vein distention, edema, pulmonary congestion, a pulsate precordium with cardiomegaly, hepatomegaly, and a gallop rhythm suggest fluid overload — a problem often encountered in patients with chronic renal failure. A systolic ejection murmur is a common finding and is related to the anemia and the increased cardiac output. Polycystic kidneys can usually be palpated. An abdominal or flank bruit suggests renovascular hypertension as the etiologic factor of the renal disease. Decreased vibratory and position sense and decreased deep tendon reflexes may be manifestations of the peripheral neuropathy of renal disease. Proximal muscle weakness is indicative of severe secondary renal hyperparathyroidism.

Laboratory studies are essential when assessing renal function and the management of the patient. The urinalysis usually shows

isosthenuria and pyuria, however, the latter can be seen in many types of renovascular disease and is not diagnostic of an infectious process. Urine cultures and sensitivity studies should be obtained if infection is considered. Blood urea nitrogen and serum creatinine values may help one to decide on therapeutic approaches if he keeps in mind that the BUN can be affected by prerenal, postrenal, as well as renal factors. The serum creatinine varies with changes in muscle mass and the nutritional status of the patient, while diet and dehydration are major prerenal factors. The BUN creatinine ratio is usually 10:1; prerenal and postrenal factors may increase this ratio; protein restriction decreases it.² The creatinine clearance is the best clinical measurement of renal function, being falsely elevated when function is significantly impaired. The urinary volume and urinary sodium excretion become less flexible as renal failure increases. A 24-hour volume of 2000cc or more suggests a better prognosis for conservative management. The sodium excretion, which is usually 30 to 40 mEq/L., may be elevated in salt-losing states. Its measure is a valuable means for adjusting a patient's sodium intake. As renal function deteriorates, protein excretion increases and contributes to malnutrition.

Other useful laboratory studies include: serum albumin (indicative of the patient's nutritional status), serum CO₂ (to determine the degree of acidosis), serum sodium, potassium, calcium, phosphorous, and alkaline phosphatase.

X-ray evaluation of kidney size can be done with a plain film of the kidneys, ureters, and bladder; intravenous pyelography alone, or, infusion intravenous pyelography with nephrotomograms can be useful in determining prognosis. Normal-size kidneys may have significant viable tissue remaining, however small contracted kidneys have little potential for functional return. It should be noted that intravenous pyelography carries some risk of precipitating acute renal failure, however, preventing dehydration diminishes the risk. A chest x-ray is needed to evaluate heart size and pulmonary vascular congestion. An x-ray bone survey is useful to ascertain renal osteodystrophy and hyperparathyroidism.

Renal biopsy is considered if the kidneys are of

normal size and severe hypertension and blood dyscrasias are not present. Biopsy of small kidneys carries a significant risk and provides little useful information, however. When faced with an obscure diagnosis, renal biopsy can provide information as to etiology and course of treatment.

Certain problems relate to specific organ systems:

Anemia — Anemia is common in chronic renal failure when the GFR drops to less than 25 percent of normal, however, symptoms related to anemia are infrequent.³ Polycystic kidney disease is an exception in that it is infrequently associated with severe anemia despite a very low GFR. The anemia is normocytic and normochromic with a near-normal reticulocyte count. In the peripheral smear, burr cells and helmet cells may be seen. Vitamin B₁₂ and folate levels are generally normal. The primary defect is due to a decrease in erythropoietin production as the renal failure progresses.⁴ Gastrointestinal absorption of iron is also decreased.⁵

The added presence of acidosis functions as a compensatory mechanism creating a shift to the right of the oxygen-dissociation curve.⁶ Hyperphosphatemia probably has a similar effect by increasing red blood cell 2,3-diphosphoglycerate and adenosine triphosphate, also causing a shift to the right.⁷ Movement to the right of the curve releases more oxygen to the tissues.

The management of the anemia involves good nutrition, iron per os, prompt treatment of infection, and prevention of alkalosis or hypophosphatemia. If the patient develops angina, transfusions should be given. When transfusion is indicated, frozen washed packed cells are preferred to reduce the risk of hepatitis, heart failure or antigen exposure which may complicate a future transplant. Hemochromatosis also may occur with frequent and repeated transfusions.

Hypertension — Hypertension is present in most patients with chronic renal failure. The most common mechanism is volume expansion due to an increase in the extracellular fluid compartment.⁸ Increased activity of the renin-angiotensin system is not usually responsible for the

elevated blood pressure. Hyperreninemic-hypertensive patients often have a significant postural decrease in blood pressure, even when they are at ideal weight. At times the supine pressure becomes more difficult to control as sodium and water removal proceed. A markedly elevated plasma renin activity confirms the impression.

The therapy of hypertension is directed toward correcting the causative factors. Readjustment of sodium and fluid intake with the use of diuretic therapy will control hypertension which is related to volume expansion. Antihypertensive medications most commonly used are methyldopa (Aldomet®) and propranolol hydrochloride (Inderal®) which decrease renin secretion, and hydralazine hydrochloride (Apresoline®) which acts as a peripheral vasodilator. Methyldopa and hydralazine do not decrease renal blood flow. A normal blood pressure should be maintained, if possible, to minimize further vascular deterioration. A transient increase in the BUN without a significant decrease in function is not uncommon when the blood pressure is normalized.

Impaired Cardiac Function — Cardiac function is important in maintaining good renal blood flow.⁹ The most common cause of poor cardiac output is arteriosclerotic heart disease related to hypertension and diabetes. Cardiomyopathy of amyloidosis also may contribute to impaired cardiac output and thus complicate the treatment. Pericarditis may occur with advancing renal failure and indicates the need to initiate dialysis.

Hyperkalemia — Potassium balance is generally well preserved until oliguria occurs. The serum potassium should be monitored and if hyperkalemia develops, it should be treated with dietary management, and if necessary, with cation exchange resins (Kayexalate®). Acidosis is common, but usually is not a problem unless the serum bicarbonate drops below 15mEq/L.¹⁰ The serum bicarbonate level is maintained by using sodium bicarbonate per os.

Secondary Renal Hyperparathyroidism — Secondary renal hyperparathyroidism develops very early in chronic renal failure.¹¹ Increased parathyroid hormone levels are present with

only a 70 to 80 percent decrease in the GFR. Serum parathyroid hormone levels continue to rise with each decrement in the GFR. When the GFR decreases to approximately 25 ml. per minute, the kidney no longer increases phosphate excretion in response to the parathyroid hormone. Vitamin D resistance also develops as the renal impairment increases, due to the kidneys' inability to produce the active metabolite of Vitamin D₃ (1,25-dihydroxy-cholecalciferol),¹² with a resultant decrease in gastrointestinal absorption of calcium. Because of the elevated levels of parathyroid hormone and the impaired absorption of dietary calcium, bone resorption occurs in order to maintain the serum calcium level. The end results are increased bone resorption and decreased bone formation. Osteoporosis, osteitis fibrosa cystica, and osteomalacia may develop.

Bone pain is the most common symptom. The serum calcium may be low, normal or high, depending on the degree of secondary renal hyperparathyroidism. Serum phosphorus and parathyroid hormone levels are usually high. Classic x-ray changes may be evident in the clavicles, skull, mandible, spine and distal phalanges. Serum acidosis tends to aggravate the bone disease because of the buffering properties of bone. A high calcium/phosphorus product is often associated with metastatic calcification.

The prevention and treatment of secondary renal hyperparathyroidism and bone disease primarily consist of controlling serum phosphorus, usually by giving oral phosphate binders.¹³ Two commonly used binders are aluminum hydroxide gel (Amphojel®) and aluminum carbonate gel (Basaljel®). Usual dosage is 30–50 ml qid. When it is necessary to restrict dietary protein, calcium supplementation can be added. Dihydratachysterol (0.1 to 0.2mg. per day), an analogue of Vitamin D₃, can be given to enhance gastrointestinal absorption of calcium and to treat the osteodystrophy. Correction of systemic acidosis also may be indicated.

Neurologic Abnormalities — The mechanism responsible for nervous system involvement in uremia is unknown. The seizure threshold appears to be diminished. The abrupt development of personality changes or psychotic

behavior indicates a poor prognosis, and conservative management should be replaced by dialysis.^{14,15,16}

Although dietary measures usually improve the central nervous system symptoms, one of the first considerations in the management of a patient with chronic renal insufficiency is to discover and correct reversible factors, such as obstruction of the urinary tract and infection. Infection should be treated with appropriate antibiotics after urine cultures and sensitivities are obtained. Sulfonamides, methenamine mandelate (Mandelamine®), and nitrofurantoin (Furadantin®) are useless in uremia because insignificant excretion occurs with renal insufficiency.¹⁷ In addition, severe peripheral neuropathy has been associated with nitrofurantoin in the presence of renal failure.¹⁸ Gastrointestinal and febrile illnesses can be managed symptomatically with fluid and electrolyte replacement. Appropriate corrective measures include replacing existing deficits and readjusting sodium and fluid intake according to the 24 hour excretion and gastrointestinal losses.

Congestive heart failure can be corrected by short-term diuretic therapy using furosemide (Lasix®) 40–120 mg/day or ethacrynic acid (Edecrin®) 50–200 mg/day, and by readjusting sodium and fluid intake. Digitalis is infrequently required, however, the dosage of digitalis also should be adjusted to the degree of renal impairment. We prefer digitoxin because it is essentially excreted by the liver and thus is not influenced by renal failure. Antihypertensive medications, such as methyldopa (Aldomet®), hydralazine (Apresoline®) and guanethidine (Ismelin®), and appropriate sodium balance usually can control blood pressure; however, antihypertensive agents and the potent diuretics should be used judiciously, with close follow-up of the patient. Cautious potassium replacement prevents the hypokalemia associated with the diarrhea of diuretic therapy.

Because of their catabolic and anti-anabolic effects, steroids and tetracycline should be adjusted to the degree of renal impairment. Cephaloridine (Loridine®) should not be administered in renal failure, however, cephalixin monohydrate (Keflex®) or sodium cephalothin (Keflin®) can be used safely.

The most important and useful therapeutic modality in the management of chronic renal insufficiency is the low protein diet as outlined by Giordano¹⁹ and Giovannetti and Maggiore.²⁰ Adequate quantities of protein of high biologic value (essential amino acids) in the diet, in conjunction with a low intake of protein of low biologic activity, promote the utilization of endogenous urea. A minimum of 0.3 gm. of essential amino acids per kilogram of body weight per day is required to maintain positive nitrogen balance. Forty to 50 calories of fats and carbohydrates per kilogram of body weight per day are required for optimum utilization of protein.²¹ Modification may be necessary for certain patients, depending on the degree of renal function, exogenous protein loss, and malnutrition. The diet is deficient in vitamins, iron, and calcium, so these must be supplemented. The effects of the dietary therapy become evident in about six weeks with dramatic improvement in the gastrointestinal and neurologic symptoms. Serum creatinine, however, continues to rise;²² while the BUN usually decreases to one-half the level preceding dietary therapy.

Summary

The optimum conservative management of chronic renal insufficiency and renal failure includes: (1) correction of reversible factors affecting renal function; (2) periodic assessment of renal function and end-organ effects with appropriate adjustment in diet, sodium and water intake, and supplementary medications, all of which improve most symptoms; (3) control of blood pressure to minimize vascular disease; (4) maintenance of optimum nutrition; and (5) control of secondary renal hyperparathyroidism and osteodystrophy.

As the underlying renal disease progresses, a point is reached where conservative management will not suffice. Associated medical complications significantly affect the patient's ability to tolerate severe renal insufficiency.

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Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only the cost of the lowest-priced, purportedly-equivalent,

generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than \$1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

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Allergy of the nervous system long has been recognized as a true entity. Despite this many physicians tend to forget allergy in the differential diagnoses and clinical management of their patients. Clinical features of the nervous system allergy include headache, insomnia, restlessness, listlessness, behavior problems, allergic "tension-fatigue" syndrome, hyperactivity, seizure, and learning disorders in children. There have been developments in immunological evaluation of nervous system diseases, especially serum sickness neuropathies, multiple sclerosis, and demyelinating diseases. However, the field has not been entirely explored. Immunological study of patients with nervous system disorders may occasionally prove helpful from the prognostic point of view, if not therapeutically beneficial at this stage.

Allergy/Immunology and the Nervous System

**Mohamad H. Zanjani, M.D.
Passaic***

Although many articles concerning the role of allergy in nervous system disorders have been published,¹⁻⁹ it is surprising that many physicians are unaware of this association.

Over the past decade, immunology has undergone a great renaissance resulting in the development of fine techniques for the investigation of various diseases, including those of the nervous system.¹⁰⁻¹⁴ This article will review some of the recent developments in the allergic and immunologic disorders of the nervous system.

History

Since ancient times, physicians have known that certain foods and other substances could cause nervous system manifestations. They had noted the relation between diet and digestion on one hand and behavior on the other. The terms hypochondria, bilious, melancholia, and so on show this. Pythagoras once said to his scholars, "Melancholy men eat no peas or beans."

Isaac Judeaus in the tenth century wrote: "beans, peas, fitches . . . fill the brain with gross fumes, breed black blood, and cause troublesome dreams."

Botallo of Leyden in 1660 reported, "I know of men who, after smelling the odor of roses, are so severely affected that they have a headache." Blackley¹⁵ in 1873, as an experiment, inhaled grass pollen to determine its effect on his nose.

This was followed not only by an attack of sneezing, but by prolonged listlessness, restlessness, and insomnia. Herzfield¹⁶ in 1911 reported that his own migraine was caused by anaphylaxis to foods. Shaw¹⁷ is probably the first to mention allergy as a cause of convulsions. He reported a case of convulsion which he thought was due to an allergy to eggs and milk.

In 1951 Susan Dees¹⁸ studied 42 children with convulsive disorders and reported that convulsions could be stopped in half of those patients with anti-allergic measures.

Allergic Tension-Fatigue Syndrome

The term "allergic tension-fatigue syndrome" was introduced by Speer in 1954 for the behavior pattern seen in some allergic children.⁴

In *allergic tension*, the patient may show motor overactivity. It may start during infancy when the child gives up naps; later he may be talkative, interrupt his teacher, and suffer from insomnia. The child has a short attention span and is slow in learning, reading, and spelling. He also may show sensory overactivity, which parents describe as nervousness, irritability, easily hurt, and so on.

In *allergic fatigue*, the patient shows a diminished neuropsychic function with weakness, fatigability and achiness. This may be musculo-skeletal in origin (allergic

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myasthenia) or it may be related to neural fatigue (allergic neuroasthenia). These children are said to suffer with "growing pains" as well as sensory fatigue.

The differential diagnosis of allergic tension-fatigue syndrome includes minimal brain dysfunction, systemic diseases such as sickle cell anemia, lead poisoning and malnutrition, as well as neuroses and psychoses.

Headache

Primary allergic headaches are the direct clinical symptoms of an allergic reaction on the central nervous system. These headaches may be frontal, localized or diffuse, or migrainous, dull or throbbing. Patients with primary allergic cephalgia may have a positive family history of allergy and/or a past history of an atopic disease. Secondary allergic headaches are seen in patients with another allergic condition, such as allergic rhinitis. In this condition the swollen turbinate membrane produces pressure against the higher septal and lateral walls and causes pain.¹⁹

Seizures

Allergy has been considered as one of the factors causing seizures. Speer²⁰ described an infant with neurological findings including right upper extremity spasms, tonic seizures, and sudden head-dropping episodes. When milk was removed from the diet, all neurological symptoms disappeared. He challenged the infant with milk, and the neurological symptoms recurred.

Many authors²¹⁻²⁶ have looked for electroencephalographic changes in allergic patients. Dees²³ reported a high incidence of abnormal EEG's in allergic patients. Fowler²⁴ compared the EEG's of patients with seizures and allergy, to those of patients with allergy alone, those who had behavior problems with and without allergies, and to a third group of normal individuals as controls. He found that the number of abnormal EEG's among all groups was higher than that in the normal controls.

Despite this, the diagnosis of allergic epilepsy is difficult, unless there is an overt allergic condition. The possibility of an allergic cause of a cen-

tral nervous system symptom should be considered if the patient has (1) an obvious allergic disease such as bronchial asthma or allergic rhinitis, (2) intermittent headache and migraine, (3) a family history of allergy, (4) seasonal periods of nervousness, tension-fatigue syndrome, and insomnia associated with pollen, molds, or other allergens, and (5) no improvement with anticonvulsant medication.

Serum Sickness Neuropathies

Serum sickness is probably seen less frequently because of the decreasing employment of heterologous sera, however, it is not a rare disease. With the indiscriminate use of penicillin, serum sickness which is usually a Type III hypersensitivity reaction as described by Gell and Coombs,²⁷ is seen sporadically. Occasionally, all four types of hypersensitivity reactions are seen with penicillin allergy.

Typical serum sickness neuropathy presents a unilateral brachial neuritis involving the fifth and sixth cervical roots. It follows the appearance of fever, adenopathy, urticarial rash, and arthralgia. Neuropathy manifests itself with pain, often burning in quality, muscle weakness, flaccid paralysis and diminished or absent reflexes; later numbness and sensory loss may be seen. Other forms of post-serum radiculoneuritis have been reported including median, ulnar, sciatic, palatal, laryngeal, facial, and trigeminal involvement. The nerve involvement is independent of the site of inoculation.

Immunological mechanisms of serum sickness neuropathy and other neurological diseases have been discussed in a recent review.²⁸ Experimental allergic neuritis has been produced by injection of the peripheral nerve (extract) and Freund's adjuvant,[†] which has a similar mechanism to serum sickness neuropathy. One or two weeks after immunization with the peripheral nerve (extract) and adjuvant the animals develop (sensorimotor) polyneuropathy. Segmental demyelination and multiple foci of mononuclear inflammatory cells are found along the course of peripheral nerves. It is

[†]Killed mycobacteria, paraffin oil, and emulsifier — used to enhance the immune response when injected with an antigen (or immunogen).

believed that cell mediated immunity is important in experimental allergic neuritis since the antigen which causes allergic neuritis has not been isolated, but the disease can be transferred with sensitized lymphocytes.²⁸

Demyelinating Diseases

It has been suggested that acute disseminated encephalomyelitis, acute hemorrhagic leukoencephalitis, and multiple sclerosis may be the result of autoimmune reactions in the nervous system.²⁹ This is based on the clinical and pathological similarities between these diseases and experimental allergic encephalomyelitis.³⁰ Production of experimental allergic encephalomyelitis is suggestive evidence that demyelinating diseases in man may have an immunological basis.

Experimental allergic encephalomyelitis may be produced in a variety of animals including guinea pigs and rats. A mixture of normal brain or spinal cord homogenate, plus Freund's adjuvant,[†] is injected intracutaneously into a laboratory animal. One to three weeks after immunization, the animal develops tremor, ataxia, hypotonia, seizures, and paralysis. Microscopic examination shows disseminated focal lesions, seen more frequently in the white matter. Inflammatory cells (mononuclear leukocytes, small lymphocytes, histiocytes, and plasma cells) appear in or around the small vessels. Swelling, fragmentation and loss of myelin are also noted. Blood serum may contain antibodies which react specifically with brain or spinal cord *in vitro*. The characteristic tissue damage of experimental allergic encephalomyelitis is organ-specific (that is, confined to the nervous system) but not species specific. Many features of this condition indicate that it is a cell-mediated immunity (Type IV hypersensitivity) reaction. Excision of the injection site one hour after injection does not prevent the occurrence of the disease, but excision of the regional lymph nodes up to four to five days after immunization prevents the condition. The disease can be transferred to nonsensitized animals by injection of a suspension of living lymph node cells from sensitized animals, but is not transferable by the sera. Lymphocytes from diseased animals are cytotoxic and myelino-

clastic for a central nervous system tissue culture. Although it is believed³¹ that cell-mediated immunity has the primary role in experimental allergic encephalomyelitis, the circulating antibodies (from immunoglobulin G) may be significant in producing or modifying the disease. Sera from the diseased animals are cytotoxic for cerebellar tissue grown *in vitro*.

There are several similarities between the clinical demyelinating diseases such as acute disseminated encephalomyelitis and experimental allergic encephalomyelitis. Both follow an incident of immunization or injection. Neurologic signs develop after a latent period, and pathologically the lesions are the same.

Multiple Sclerosis

The exact immune mechanism in multiple sclerosis is not clearly known. However, the immunoglobulin abnormalities in this disease have been described by various investigators including Link.³² There is a relative increase in concentration of IgG and sometimes of IgA in the cerebrospinal fluid of patients with multiple sclerosis. This finding cannot be explained by simple influx from serum, in which the concentrations are almost always normal. The most likely explanation is that IgG and in some cases IgA as well is synthesized within the central nervous system. There is also some evidence that concentrations of IgG are raised in plaques as well as in the apparently normal white and grey matter in the brain of patients with multiple sclerosis. It is of interest to know that increased IgG concentrations in the central nervous system have been reported in patients with great disability and with signs of multifocal damage. Also significantly increased concentrations of IgG and IgA recently have been demonstrated in cerebrospinal fluid specimens obtained during exacerbations of multiple sclerosis when compared with specimens obtained during remissions from the same patient. Therefore, measurement of immunoglobulin in spinal fluid has some prognostic value. It should be pointed out that a relative increase in IgG concentration

[†]Killed mycobacteria, paraffin oil, and emulsifier — used to enhance the immune response when injected with an antigen (or immunogen).

in spinal fluid is not specific for multiple sclerosis; it occurs in various infectious disorders of the nervous system in about 40 percent of cases and in neurological disorders other than MS or infections in about 15 percent of cases.

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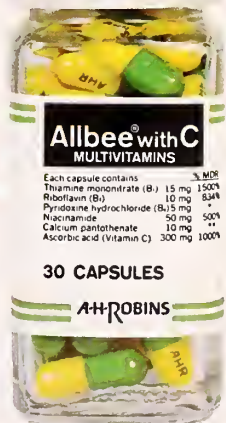
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A case of spontaneous asymptomatic pneumoperitoneum secondary to jejunal diverticulosis is reported. Recognition of the general benign clinical course of this unusual condition is stressed. A review of other causes of asymptomatic pneumoperitoneum and a discussion of clinical problems rarely encountered with jejunal diverticulosis are also presented.

Spontaneous Asymptomatic Pneumoperitoneum Secondary to Jejunal Diverticulosis

Alan J. Simpson, M.D., Northfield

Spontaneous asymptomatic pneumoperitoneum is both an uncommon event and a rare complication of jejunal diverticulosis. Recognition of this entity is important if unnecessary surgery for a suspected perforation of the gastrointestinal tract is to be avoided. A recent encounter with this unusual clinical problem prompted this report.

Case Report

A 70-year-old female had a chest radiograph as part of her regular physical examination for treatment of hypertensive heart disease. Free air was noted below the diaphragms (Figure 1). She was completely asymptomatic and demonstrated no physical findings of an acute abdomen. Her past medical history lacked any gastrointestinal complaints. Laboratory tests which included complete blood counts, urinalysis, and 12 channel chemistry analyses were normal. An x-ray of the abdomen in the supine position disclosed peculiar bubbly collections of gas in the left upper quadrant (Figure 2).

An upper gastro-intestinal tract and small bowel x-ray study performed that day exhibited multiple diverticula arising from the duodeno-jejunal junction and most of the jejunum (Figures 3A,3B). A barium enema x-ray and intravenous urogram were normal. A repeat chest examination five days later revealed complete resolution of the pneumoperitoneum. The patient remained asymptomatic.

Discussion

Pneumoperitoneum is generally considered pathognomonic of gastrointestinal rupture. To develop a spontaneous pneumoperitoneum without peritonitis, the leak must be small enough to permit the escape of gas without bowel contents, and the resistance of the peritoneum to infection must be intact.¹



Figure 1 — Postero-anterior upright chest radiograph. Curvilinear lucencies below the diaphragms represent free air.

The more common etiologies of spontaneous asymptomatic pneumoperitoneum include: (1) entry of gas via the female genital tract, e.g., from sudden squatting due to postpartum factors or a Rubin test; (2) a forme fruste perforation of a peptic ulcer; (3) rupture of an air cyst complicating pneumatosis cystoides intestinalis, and (4) dissection of air down from the thorax into the extraperitoneal tissues with rupture into the peritoneum in patients with chronic obstructive lung disease. Gas may also leak through a markedly distended stomach.²



Figure 2 — AP supine view of the abdomen. Multiple gas bubbles in the left upper quadrant.

The majority of patients with jejunal diverticulosis are asymptomatic; the condition is an incidental finding at abdominal surgery or gastrointestinal radiologic study for unrelated conditions.^{3,4}

These acquired diverticula arise on the mesenteric border at points of potential weakness where blood vessels enter the bowel. The thin-walled, wide-mouth sacs are composed of mucosa, sub-mucosa, and muscularis mucosa. The muscularis propria is lacking.⁴

Clinical symptoms attributable to jejunal diverticula are unusual, but may consist of vague abdominal distress, borborygmi or excessive flatulence. Less than 10 percent of patients develop complications which may require surgical intervention. In addition to asymptomatic perforation, other rare complications include volvulus, bleeding, macrocytic anemia (similar to that associated with a blind loop syndrome), diarrhea secondary to a malabsorption syndrome, acute inflammation and obstruction.^{4,5,6,7} Obstruction is believed to be non-



Figure 3a — Multiple barium-filled jejunal diverticula corresponding to the gas collections noted in Figure 2 — 30 minute prone film.



Figure 3b — Barium trapped within wide-mouthed diverticula sacs (upright view).

mechanical and to result from intestinal dyskinesia with large fluid-filled diverticula disturbing normal peristalsis.³

It is important to realize that subdiaphragmatic free air, without signs of peritoneal inflammation can occur in patients with jejunal diverticulosis. Since the vast majority of these patients are asymptomatic and remain so, conservative management is proper.

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Methyltestosterone U.S.P. – 5, 10, 25 mg.

New Double-Blind Study ANDROID-25 vs. Placebo*

* **WRITE FOR REPRINT:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioğlu, M.D., "Hormones for Improved Sexuality in the Male and Female Climacteric," *Drug Therapy*, Sept. 1976.

Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25

(methyltestosterone 25 mg.), on 20 males, 50 years of age or older who complained of secondary impotence. Patients received a series of placebo then Android-25, or Android-25 then placebo as follows: 1 tablet/30 days, 2 tablets/30 days, 3 tablets/30 days. Sexual response was evaluated: 0 = no change; + = 25% improvement; ++ = 50% improvement; +++ = 75% improvement. Placebo effectiveness was – or ++ in 12.7% of trials. Android-25 elicited a +, ++ or +++ response in 47.2% of trials. There was often a dose related response not observed with the placebo. This effect was not observed in younger patients (age 28-45 years).

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-pubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg. Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg. Postpubertal cryptorchidism, 30 mg. **REFERENCE:** Robert B. Greenblatt, M.D., and D. H. Perez, M.D.: *The Menopausal Syndrome*, "Problems of Libido in the Elderly," pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

A measles epidemic of 5,837 reported cases occurred in New Jersey from July 1, 1973 to June 30, 1974. Of this total, 2,649 cases were in the 13-18 year age group. Bergen County accounted for 2,614 (44.8%) cases of which 1,540 were in the 13-18 year age group. Two communities in Bergen County were selected to do immune status surveys. In Community A, 31 of the 172 cases had a documented history of previous measles vaccine. In Community B, 22 of the 75 cases had a documented history of previous measles vaccine. Based on the measles immunity surveys, attack rates by community and by immune status were calculated. The attack rates in the secondary school population, which was the focal point of the outbreaks, were 1.9 for vaccinated students and 33.3 for susceptible students in Community A; and 3.6 for vaccinated students and 27.9 for susceptible students in Community B. Based on these attack rates, the vaccine efficacy rates were 94.3 percent and 87.2 percent respectively in the two communities. The study also revealed that immunity levels of 90.1 percent and 95.8 percent in secondary school populations did not prevent the spread of measles.

Measles Epidemic in New Jersey

Vaccine Efficacy Study in a Well-Protected Population

Leah Z. Ziskin, M.D. and Linda G. Dimasi, B.S./Trenton*

Since its licensure in 1963, live attenuated measles virus has been used and accepted as a safe and effective vaccine. As a direct result of a national effort to eradicate measles in 1966, the number of annual reported cases has decreased dramatically.¹ However, from July 1, 1973 to June 30, 1974, New Jersey experienced 5,837 reported measles cases. This was the largest number of cases in New Jersey since 1965. (See Figure 1) In the national measles epidemic during the winter and spring of 1970-1971, the effectiveness of live, attenuated measles virus vaccine was questioned.²⁻⁷ This same concern, eleven

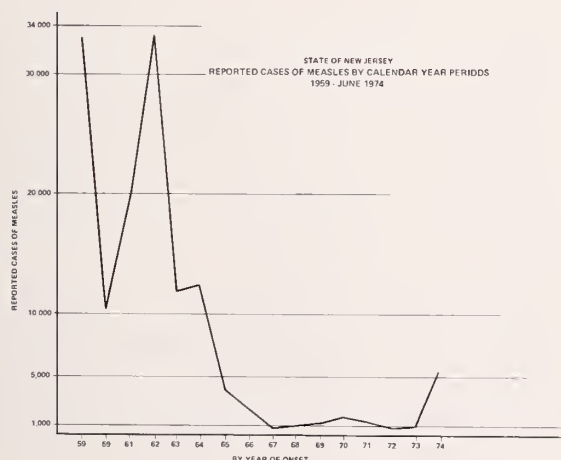
years after the vaccine was licensed, was again expressed during the New Jersey epidemic.

In this epidemic, 45 percent of the reported cases were in the 13 to 18 year-old age group. Bergen County accounted for 2,614 cases or 44.8 percent of the total number of reported cases of which 1,540 were in the 13 to 18 year-old age group. (See Table 1) Two communities in Bergen County were therefore selected as sites to study measles vaccine efficacy.

Background

It is usual program procedure that cases of measles reported to the New Jersey State Department of Health, Communicable Disease Program, by local health departments, school nurses, hospitals, institutions or private physicians are investigated and confirmed by a nurse epidemiologist and a specially trained surveillance case worker. In keeping with this procedure, interviews with mothers of infected children were conducted by telephone. Some

Figure 1



Dr. Ziskin is Director of Parental and Child Health Services, Division of Community Health Services, and formerly Chief of Communicable Disease Program, New Jersey State Department of Health. Ms. Dimasi is Senior Field Representative, Health Vaccination Assistance Program, Division of Laboratories and Epidemiology, New Jersey State Department of Health. The authors acknowledge the assistance and contribution of Ronald B. Altman, M.D., Director of Epidemiology Services, especially in reference to the concept of disease efficacy.

Table 1
Measles Morbidity — New Jersey
Numbers and Age-Specific Rates per 100,000 Population
 July 1, 1973 — June 30, 1974

Area	All Ages		0-4		5-12		13-18		19+	
	Number	Rate	Number	Rate	Number	Rate	Number	Rate	Number	Rate
New Jersey	5,837	78.9	816	134.1	2,223	191.2	2,649	327.5	129	2.7
Atlantic County	8	4.4	4	29.3	2	7.5	—	—	2	1.6
Bergen County	2,614	286.8	54	83.6	959	701.8	1,540	1501.2	56	9.2
Burlington County	71	21.8	15	52.9	24	41.8	29	75.3	3	1.5
Camden County	272	56.9	57	137.2	122	154.2	89	164.0	4	1.3
Cape May County	1	1.6	—	—	1	12.0	—	—	—	—
Cumberland County	11	8.6	1	8.5	9	43.2	1	7.0	—	—
Essex County	456	48.3	196	247.0	155	110.2	94	94.9	10	1.6
Gloucester County	148	81.4	27	161.5	88	271.4	30	140.2	2	1.8
Hudson County	329	53.7	81	173.2	117	142.9	125	206.5	5	1.2
Hunterdon County	4	5.4	1	16.2	1	8.0	2	23.4	—	—
Mercer County	71	22.6	36	143.4	29	63.3	4	11.7	1	0.5
Middlesex County	381	63.0	18	33.4	135	131.6	217	308.8	6	1.6
Monmouth County	12	2.5	2	4.7	8	9.6	—	—	2	0.7
Morris County	129	32.1	9	24.0	57	80.2	58	130.7	5	2.0
Ocean County	82	33.7	2	9.6	63	163.2	17	71.9	—	—
Passaic County	841	178.8	287	720.1	290	414.3	240	494.7	19	6.1
Salem County	28	44.1	6	112.6	12	114.3	10	133.2	—	—
Somerset County	15	7.3	—	—	10	27.3	2	8.4	2	1.6
Sussex County	82	97.1	4	48.7	37	244.1	38	416.0	3	5.8
Union County	276	50.1	16	40.5	99	123.5	152	251.3	9	2.4
Warren County	6	7.8	—	—	5	4.3	1	11.6	—	—

personal visits were made to homes, hospitals, and institutions especially when there were clusters of cases. School nurses were contacted for additional cases whenever a case in a school-aged child was reported. Information about the child's age, attendance at school or day care center, onset of illness, symptoms, history of vaccination or past disease, and possible source of exposure was obtained. A list of siblings, their ages as well as their vaccination histories, was also sought.

Clinical criteria for a diagnosis of measles were (1) several days of typical prodromal symptoms: fever, cough, coryza, and conjunctivitis; (2) a rash of five or more days' duration with distribution over the face, neck and trunk; (3) a history of Koplik spots if seen by a physician. A physician's diagnosis was accepted if the case was seen, or if a positive diagnosis was made on a sibling or household contact.

Laboratory confirmation of measles disease by hemagglutination inhibition and complement fixation was obtained in 37 cases, 8 of which

were in Bergen County. Laboratory tests were performed by the New Jersey State Department of Health Laboratory.

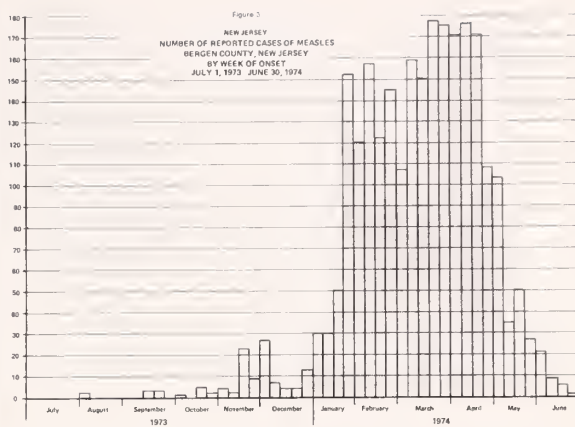
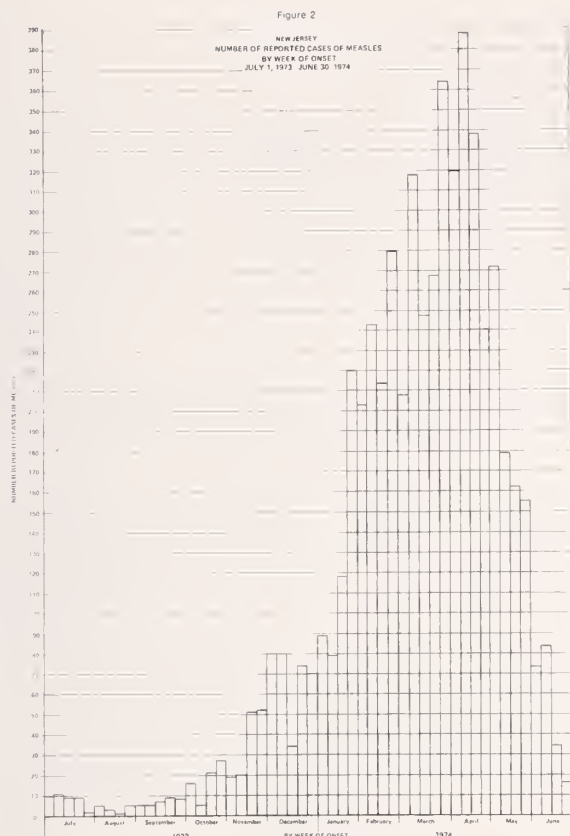
Figure 2 is the epidemic curve of the 1973-74 state-wide measles epidemic and Figure 3 is the epidemic curve of the 1973-74 Bergen County measles epidemic derived and confirmed by the procedures and techniques described above.

Vaccine Efficacy Study

The vaccine efficacy study was designed to answer the following questions.

1. Were effective immunity levels maintained for time intervals longer than reported in previous measles vaccine efficacy studies?
2. Did an epidemic occur in a well-protected population of secondary school aged children?

Two communities in Bergen County, A and B, were selected for the vaccine efficacy study. Both of these middle-class suburban towns are similar in their socio-economic status and were thought to be representative of communities in Bergen County.



1. Having had the disease prior to January 1, 1974 (the date of disease was recorded).
2. Having had measles virus vaccine prior to January 1, 1974 (the date of immunization was recorded).
3. Susceptible (no history of disease or vaccine as of January 1, 1974).

Students with a history of both the disease and vaccine were placed into the category with the earlier date, which usually was a history of disease.

The parents of students with no information on their health records were sent a questionnaire the results of which were added to the tabulations of the survey.

Results

Community A — Figure 4 depicts the epidemic curve of measles in this town. The arrows in March and June indicate when community immunization clinics were held.

There was significant morbidity in the junior and senior high schools of these communities. Over 85 percent of the school health records had current reliable information; therefore a minor amount of follow-up by individual letters or phone calls was required.

Each student was categorized as follows, after an examination of his health record.

Table 2

Measles Status of Students in Community A Junior and Senior High Schools Prior to January 1, 1974.

Grade (as of 6/74)	No. of Students with History of Vaccine	No. of Students with History of Disease	No. of Students Susceptible	No. of Students of Unknown Status	Total
12	144	342	49	76	611
11	208	332	66	64	670
10	211	278	63	63	615
9	319	211	62	37	629
8	350	158	50	34	592
7	389	102	43	15	549
Total	1621	1423	333	289	3666

Note: (1) Status known for 92.1% of total enrollment. (2) Protection Rate before the outbreak was 90.1%.

The Vaccine Efficacy (V.E.) was computed by the formula:

$$V.E. = \frac{ARS^a - ARV^b}{ARS^a} \times 100$$

$$V.E. = \left[\frac{\left(\frac{111 \times 100}{333} \right) - \left(\frac{31 \times 100}{1621} \right)}{\left(\frac{111 \times 100}{333} \right)} \right] \times 100$$

$$V.E. = \left(\frac{33.3 - 1.9}{33.3} \right) \times 100 = 94.3\%$$

^aAttack Rate of Susceptibles

^bAttack Rate of Vaccinated

The health records were surveyed in Community A Senior High School for grades 10 through 12; the enrollment in this school as of June 1974 was 1896. The records in the two junior high schools (grades 7, 8 and 9) also were examined. The combined enrollment of the latter, as of 1974, was 1,770. The health survey was done on the records of students enrolled during the 1973-74 school year (Table 2).

Table 3 categorizes the cases of measles in secondary school students in Community A.

Table 3

Measles Morbidity in Students in Community A Junior and Senior High Schools from January 1 through June 30, 1974.

	Number
Measles cases with history of vaccine prior to January 1, 1974	31
Measles cases with a history of measles disease prior to January 1, 1974	30
Measles cases in those students with no history of vaccine or disease prior to January 1, 1974	111
Total	172

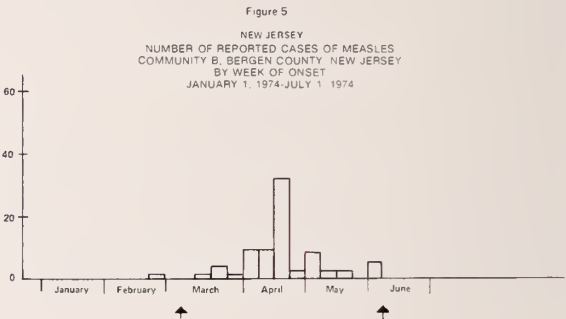
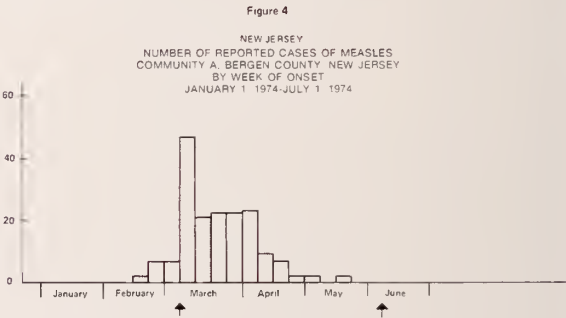
Referring to Table 3, one notes that the number of measles cases with a prior history of disease is very similar to the number of measles cases with prior history of vaccine. The Measles Disease Efficacy (D.E.) was computed as follows:

$$D.E. = \frac{ARS^a - ARPD^c}{ARS^a} \times 100$$

$$D.E. = \left[\frac{\left(\frac{111 \times 100}{333} \right) - \left(\frac{30 \times 100}{1423} \right)}{\left(\frac{111 \times 100}{333} \right)} \right] \times 100$$

$$D.E. = \left(\frac{33.3 - 2.1}{33.3} \right) \times 100 = 93.7\%$$

^cAttack Rate of those with Prior Disease



Community B — Figure 5 depicts the epidemic curve of measles in Community B. The arrows in March and June indicate when community immunization clinics were held.

The health records for the 1973-1974 school year were surveyed in Community B High School, which contains grades 9 through 12. The enrollment in this school as of June 1974 was 1,937. (Table 4)

Table 5 categorizes the cases of measles in secondary school students in Community B.

Table 4

Measles Status of Students in Community B High School Prior to January 1, 1974

Grade (as of 6/74)	No. of Students with History of Vaccine	No. of Students with History of Disease	No. of Students Susceptible	No. of Students of Unknown Status	Total
12	47	394	6	23	470
11	137	285	17	11	450
10	172	278	41	12	503
9	259	235	15	5	514
Total	615	1192	79	51	1937

Note: (1) Status known for 97.4% of total enrollment.

(2) Protection Rate before the outbreak was 95.8%

Table 5

Measles Morbidity in Students in Community B High School from January 1, 1974 through June 30, 1974

	Number
Measles cases with a history of vaccine prior to January 1, 1974	22
Measles cases with a history of measles disease prior to January 1, 1974	31
Measles cases in those students with no history of vaccine or disease prior to January 1, 1974	22
Total	75

$$D.E. = \frac{ARS^a - ARPD^c}{ARS^a} \times 100$$

$$D.E. = \left[\frac{\left(\frac{22}{79} \times 100 \right) - \left(\frac{37}{1192} \times 100 \right)}{\left(\frac{22}{79} \times 100 \right)} \right] \times 100$$

$$D.E. = \left(\frac{27.85 - 2.60}{27.85} \right) \times 100 = 90.7\%$$

^cAttack Rate of those with Prior Disease

The Vaccine Efficacy (V.E.) was computed by the formula:

$$V.E. = \frac{ARS^a - ARV^b}{ARS^a} \times 100$$

$$V.E. = \left[\frac{\left(\frac{22}{79} \times 100 \right) - \left(\frac{22}{615} \times 100 \right)}{\left(\frac{22}{79} \times 100 \right)} \right] \times 100$$

$$V.E. = \left(\frac{27.85 - 3.58}{27.85} \right) \times 100 = 87.2\%$$

^aAttack Rate of Susceptibles

^bAttack Rate of Vaccinated

Referring to Table 5, one notes that the number of measles cases with a prior history of disease is again very similar to the number of measles cases with prior history of vaccine. The Measles Disease Efficacy (D.E.) was computed as follows:

Although date of vaccination was recorded for students with a history of vaccine, it was impossible to obtain information concerning the type of vaccine (killed, live attenuated, or further live attenuated) that the student had received in 1963, 1964 and 1965. Therefore, it was necessary to include these students with those students who had received live vaccine "as immune." The resulting vaccine efficacy rates (Community A 94.3 percent, Community B 87.2 percent) demonstrate that the use of measles vaccine is highly effective in protecting against measles.⁸ If this were not the case, one would expect the attack rates of students with histories of vaccine to be similar to those of unvaccinated susceptibles. This did not occur in either community.

Because of the large number of students with a history of disease prior to January 1, 1974, the disease efficacy was calculated. The resulting disease efficacy for Community A was 93.7 per-

cent and for Community B it was 90.6 percent. When comparing the vaccine and disease efficacy rates of the individual communities, one notes how similar they are (Table 6).

Table 6
Comparison of V.E. and D.E.

	Vaccine Efficacy	Disease Efficacy
Community A	94.3%	93.7%
Community B	87.2%	90.6%

The data demonstrated that major measles outbreaks occurred in well-protected populations. Community A had a protection rate of 90.1 percent and Community B had a protection rate of 95.8 percent in the secondary school populations before the outbreaks.

Comment

The results of this study were not totally unexpected. Effective immunity levels were maintained in immunized individuals for time intervals longer than in previously reported measles vaccine efficacy studies (eleven years after vaccine was licensed); and a measles epidemic occurred in well-protected populations.

Linnemann, *et al.*⁹ have been studying the antibody titers obtained after clinical measles where cases occurred in previously vaccinated children. His results as well as others have suggested that clinical measles occurs in two different populations of children who previously received live measles virus vaccine. In one group it represents a primary infection and in the other, a reinfection. Studies should continue in an attempt to explain why this happens.

It must be recognized, however, that measles epidemics are likely to occur with cases categorized into three groups:

1. Those with no history of prior disease or vaccination.

2. Those with history of prior disease.

3. Those with history of prior vaccination.

This study and prior studies demonstrate that the attack rate of individuals with no history of prior disease or vaccination is significantly greater than the attack rates of individuals in the other two categories.

The results substantiate currently recommended public health policies for measles immunization: all children between the ages of 15 months and 18 years be immunized with live measles virus vaccines and that revaccination of children so immunized is not indicated.

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P.O. Box 1540, Trenton

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U.S. Public Health Service (1974)

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*B. Blackwell: The Drug Defaulter. *Clinical Pharmacology and Therapeutics* 13:841 (1972).

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CASE REPORT

A three-compartment bladder with a cloverleaf configuration was reported in an adult male. The findings were consistent with bilateral diverticula which were interpreted as congenital in origin. The literature is reviewed, and the similarities and differences between congenital and acquired bladder diverticula are discussed.

CLOVERLEAF BLADDER*

Lewis Rubin, M.D. and Bernard D. Pinck, M.D./ Passaic

A bladder diverticulum is an outpouching of mucosa which may include a variable muscular component. In 1849, Rokitansky first described bladder diverticula which were associated with urethral obstruction.¹ Herein, we report a case of a three-compartment bladder with a cloverleaf appearance in an adult male. On the basis of roentgenographic studies, as well as endoscopic and operative visualization, the findings were consistent with bilateral diverticula which were thought to be congenital in origin.

Case Report

The patient was a 64-year-old male with a one-month history of slow urinary stream, frequency, and intermittent hematuria. He was otherwise in good health. On admission his temperature and physical examination were normal; the prostate was smooth, non-tender and moderately enlarged. Urine was grossly bloody with 15-20 WBC/hpf on microscopic examination. Hemoglobin was 15 gm/dl. and the BUN and creatinine were normal. Two urine cultures grew staphylococcus epidermidis with a colony count over 100,000. Intravenous pyelogram revealed bilateral renal mass lesions and a bladder with three components (Figure 1). Nephrotomograms disclosed bilateral renal cysts. Endoscopy revealed an occlusive prostate, a markedly inflamed bladder mucosa, mild trabeculation and a small bladder capacity. Two large diverticula, each with an ostium measuring two cm. in diameter were noted close to the lateral aspects of the bladder neck. The trigone could not be identified, but indigo carmine, which had been given intravenously, was noted to efflux deep from within the diverticular ostia. A cystogram demonstrated two orange-sized, smooth diverticula, which were somewhat irregular in configuration, and a small central bladder component (Figure 2, A,B). A film taken promptly after the bladder was drained revealed relatively small amounts of residual contrast media in the diverticula (Figure 2, C). The bladder was explored and the endoscopic findings were confirmed. An abscess above the right diverticular ostium was drained. The small central component of the bladder was mildly trabeculated. No tumors were observed in the diverticula. A diverticulectomy was not performed as this would have left the patient with an inadequate bladder capacity, but a suprapubic cystostomy tube was left in place. Through and through neomycin irrigations were administered. He then underwent transurethral resection of the prostate. Post-operatively, the



Figure 1. IVP, bilateral calyceal distortion suggests renal mass lesions. The bladder appears to have three components.

suprapubic wound promptly closed after the cystostomy tube was removed. The patient voided well following the procedure.

Discussion

There are several findings which led us to believe that the patient had congenital bladder diverticula. Until the recent onset of his symptomatology, the patient did not have frequency or nocturia which might have been expected without the added capacity of the diverticula.

*This case report is from the Dept. of Urology, Beth Israel Hospital, Passaic, New Jersey



(a) Anteroposterior. Irregular central bladder and two large diverticula.

The diverticula had relatively broad necks; the fact that they drained well suggested the presence of a significant muscle layer, although a biopsy was not performed. The finding of unobstructed upper tracts and the absence of reflux, despite the inclusion of the ureteral orifices well within the diverticula, may be evidence for early fetal development of the diverticula. The absence of significant bladder trabeculation in the presence of diverticula is further evidence of a congenital origin of the diverticula.

Vesical diverticula are classified as either congenital or acquired in their development. It is well known that acquired diverticula are most commonly seen in older men. Hinman believes that all acquired diverticula are secondary to outlet obstruction, either anatomical or neurological in nature.² Acquired diverticula have little or no muscle components, whereas congenital diverticula may have a substantial muscle layer. When chronic infection is present, the muscle component may be destroyed and



(b) Right posterior oblique. Foley catheter balloon is seen in the bladder with two large, smooth, somewhat irregular diverticula.



(c) Post drain. A relatively small amount of residual contrast media remains in the diverticula.

replaced by fibrosis of the wall. Reports of a five-month-old fetus with a bladder diverticulum composed of normal bladder muscle,³ and other cases of diverticula in children unassociated with outlet obstruction, support the concept of congenital diverticula.^{4,5,6,7} Congenital diverticula may empty well if the neck is broad and a substantial muscle component is present. Congenital diverticula, which are much more common in boys than girls, may remain asymptomatic for years. Symptoms associated with urinary tract infection, including hematuria, lead to the diagnosis of bladder diverticula.

Most congenital and acquired diverticula communicate with the bladder in the region just above and lateral to the ureteral orifices. Diverticula present at the dome are believed to represent the persistence of an unobliterated urachus. The most widely accepted theory of the origin of both types of diverticula is an inherent weakness in the bladder wall in the region above and lateral to the ureteral orifices. This weakness may be explained by the dual origin of germ layers in the development of the bladder, the trigone being derived from mesoderm, whereas the remainder of the bladder is entodermal in origin. Also, the ureter, in passing through its hiatus, creates a natural weakness in the muscle wall, the size of which determines the width of the neck.⁴ Normal voiding pressures are sufficient to initiate the development of congenital diverticula, whereas acquired diverticula are

associated with increased intravesical pressures.

Congenital diverticula are usually diagnosed in association with an evaluation of symptoms of infection. Congenital diverticula may be associated with reflux when the orifice is incorporated in the mouth of the diverticulum. Ureteral obstruction may occur secondary to distortion and compression of the intramural ureter. Urinary retention may occur when the diverticulum compresses the posterior urethra. When diverticula are associated with infection, obstruction, or reflux, the treatment is surgical excision, sometimes requiring reimplantation of the ureter as well.

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Beth Israel Hospital, Passaic

Doctor*

"Many physicians would like to limit the title *doctor* to those in the medical profession, but there are today probably many more non-medical men and women entitled to the title than there are within the medical profession.

"Actually, it was not until the Middle Ages that the title acquired a specifically medical connotation. The first *doctors* were teachers, for the word comes directly from Latin and is the noun formed from the verb 'docere,' meaning 'to

teach.' Originally it was applied to any learned man. Indeed, in many parts of the world today, *doctor* is simply an honorific for any wise man, whether or not he has graduate degrees. In the United States it is applied properly to any person who has a doctoral degree in any branch of learning, whether it be academically earned or honorary."

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MEDICAL HISTORY

Confrontation in New Jersey

The Hospital Versus the Line

Morris H. Saffron, M.D., Passaic*

As a prelude to the little-known episode to be described and documented in this paper a brief review of the early history of the Medical Department of the Continental Army is essential. When Washington assumed command of the forces at Cambridge in July, 1775 there was virtually no semblance of an organized department, and it was only at the Commander's insistence that a reluctant Congress finally granted authorization for such an establishment. The first Surgeon-General, Benjamin Church, immediately found himself at loggerheads with line officers who refused to acknowledge his authority over their pet regimental surgeons.

It is necessary also to say a few words about the training, competence, and ethics of these medical volunteers. The vast majority were younger men who had received their training through an apprenticeship varying greatly in length and quality; while they all knew how to bleed, blister, and bandage, many had but the vaguest notion of the principles and practice of medicine, and only a few were capable of amputating a limb or probing the chest and abdomen. Political appointees who had taken no formal qualifying examinations, they often curried favor with their line officers by ordering extra rations from the commissary which never reached the trays of the sick and wounded. Nor were others above making a dishonest dollar: Somewhat later a Doctor Hall "was drummed out of his regiment of the American camp at Harlem for selling soldiers sick certificates that they were unfit for duty." Even the usually tolerant Washington, shocked at their incompetence and neglect, once categorized the regimental medical personnel as a group of "great rascals" who were resolved to destroy the Hospital (Medical Department).

In his efforts to exercise some supervision over the activities of the regimental surgeons, Director Brooks found himself opposed by Major

General John Sullivan, who, as we shall see, continued to resist such intrusion on the traditional prerogatives of the line. Sullivan, a New Hampshire lawyer turned soldier, was pompous but generally inefficient, and was later accurately described by one Congressional delegate as "the marplot of the army." Before Brooks could carry out his intended reforms, he was himself accused of treasonous correspondence with the enemy, jailed, and removed from office.

As a replacement for Brooks, Congress appointed John Morgan of Philadelphia, one of the most distinguished physicians in the Colonies. Morgan had fought as a line officer in the French and Indian War, obtained a medical diploma from Edinburgh, met Voltaire and Morgagni on his triumphal grand tour of Europe, and returned home to help found the first formal medical school in the colonies. A man of high ethical and educational standards, Morgan was aghast at the incompetency he found around him, but he had no better success than Brooks in coming to a rapprochement with the regimental surgeons. His efforts were nullified by Sullivan who probably encouraged the politically-minded surgeons to appeal to Congress that they were being discriminated against in the matter of the distribution of supplies. It is true that Morgan, laboring to preserve his woefully inadequate caché of drugs and medical material, was reluctant to distribute large quantities to be squandered by undisciplined surgeons' mates.

This was the unhappy situation in sultry, disease-ridden New York City when the disastrous defeat on Long Island (August 26, 27, 1776) confronted Morgan with the emergency he had been anticipating. As Washington began his retreat up Manhattan, Morgan worked like a Trojan, supervising the ferrying of thousands of

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sick and wounded to Jersey where emergency hospitals had been established at Newark and Hackensack. He made repeated trips under the fire of British gunboats to rescue his precious stores, "like a brand from the burning," winning for his zeal the commendation of the Commander-in-Chief. But the field hospital established at Harlem soon became hopelessly infected with typhus, typhoid, and dysentery, and the high mortality at this place was unjustly used by the regimental surgeons to discredit Morgan. In the meantime his position with Congress was being further undermined by an arch-rival, William Shippen, Jr., a former colleague at the Philadelphia Medical College. Shippen, who at first thought he could sit out the entire rebellion, had used powerful connections in Congress to obtain a position as the chief medical officer of the Flying Camp in New Jersey. Unwilling to act in any capacity implying inferiority to Morgan, he later persuaded Congress to divide the medical command at the line of the Hudson, thus giving Shippen complete autonomy in the area west of the river. On the same day, October 9, undoubtedly at Shippen's suggestion, Congress passed a resolve "that no regimental hospitals be, in future, allowed in the neighborhood of the general hospital." The immediate effect of this ill-advised legislation was to widen still further the breach between the regimental surgeons and the hospital staff.

With the fall of Fort Washington on November 13th, Washington and his staff crossed over to New Jersey, and began the dismal retreat which was not to end until the crossing of the Delaware into Bucks County. Morgan, whose activities were now limited to the east side of the Hudson, was naturally reluctant to turn over his stores; it required a stern warning from Congress and even from the sympathetic Washington to persuade him to do so. On his retreat through New Jersey Washington had been joined by a number of surgeons, including Dr. John Cochran of New Brunswick. A veteran of the French and Indian War, a founder of The Medical Society of New Jersey and an expert in the procedure of inoculating against smallpox, Cochran was a man of considerable distinction, and a valuable addition to the medical staff.

He soon saw action at Trenton and Princeton, becoming an accepted member of Washington's

"family" when the army settled down for the winter at Morristown. Responding to public clamor for a medical scapegoat Congress, on January 9, 1777, ordered the dismissal of John Morgan without indicating a cause. Shippen, now more confident than ever of his forthcoming promotion, presented Washington with a plan for organizing the Medical Department. Washington, however, showed respect for Cochran's military experience by insisting that the plan meet with his approval before being sent on to Congress. On April 11th, both men were promoted. Shippen became the third Director General and Cochran assumed Shippen's position as head of the Flying Camp Hospital. The two men, determined to elevate standards, advertised for well qualified men to join the service and ordered the unpopular procedure of re-examination for the regimental mates.

This was the situation in May, 1777 when Washington moved his men out of winter quarters. Sullivan, still determined to assert his authority over the Surgeon General wrote to Shippen, ordering him to establish a hospital at Princeton to be commanded by one of his battalion surgeons, Charles Ridgely of Maryland. Here is Shippen's firm refusal:

May 29, 1777

Dear Sir

I am favor'd with yours of the 27th Inst. & beg leave to observe that the inconvenience or danger of moving any sick from your division to Trenton, will be vastly less than will arise from establishing a separate Hospital at Princeton. The danger will be less when we consider that it is expressly ordered by Congress, that every sick soldier shall be sent to a continental Hospital, as soon as any other diet or lodging becomes necessary for him, than what is allowed to all Soldiers. All Regimental Hospitals are absolutely forbid by Congress too, which puts it out of my power to comply with your order in favor of Dr. Ridgely's requisition. The sick of the 4th Maryland and every other Battalion in your division as soon as they are proper subjects for a Hospital, must be sent to the Hospital at Trenton where no cost or pains is spared to make them happy & comfortable. All sudden accidents or wounds will be taken care of by Dr. Cochran, in a branch of his flying Hospital, as soon as he can erect one on your side ye Raritan. Wishing you success against the common enemy.

I have the honor to be Dr Sir
Your very humb. Servt
W. Shippen Jr.

General Hospital
May 29, 1777

(Verso)
The Honble. Major General Sullivan
at
Princeton

Now more than ever aroused Sullivan sought for some pretext to discredit these regulations of Congress. At the end of June he wrote a letter of complaint to Washington insisting that some twenty-five sick men of his division had been arbitrarily denied admission to the General Hospital. Shippen turned the letter over to Cochran whose reply follows:

(Middlebrook)
Sir

July 3rd, 1777

Your Letter of Complaint to General Washington, against the Surgeons of the General Hospital is now before me. You charge us with detaining a Number of Sick, belonging to Colonel Hazen's Regiment, of refusing to receive them into the Hospital, and of sending them away at Nine O'Clock at Night through the Rain. Whoever gave you this Information is a Stranger to the Truth, and it would have been well that you examined a little more particularly into the State of this Matter, before you had lodged your Complaint. At half an Hour after seven O'Clock on Sunday Night Word came from Colonel Hazen's Regiment 25 Sick to be admitted into the Hospital, there was no Return sent with them, nor had I any Place to accomodate them in, at that unseasonable Hour; and had I not returned them to their Regiment, where I presume they had Tents, they must have lain in the open Field and perished.

I ordered the person who came with them, to bring them back in the Morning, with a proper Return signed by the surgeon and I would provide Waggon to transport them to the General Hospital. They were not returned to me till late the next Evening, when I ordered the person who had the charge of them to a Barn over the Mountain which I had occupied for the purpose of an hospital, the men suffered from being out at that late Hour, especially as it rained at Times, and the Evening was very damp.

The Sick of Colonel Hazen's and Hall's Regiments were received into the General Hospital yesterday, without an orderly Man or Woman sent with them, tho there is a general Order for a proportionable Number of Women from the different Regiments to attend the Sick, when sent to the Hospitals at Black River or Mendham, You may acquaint the Gentlemen Colonels of your Division that I will receive no Sick into the hospital, without a proper Return of the Mens' Names, their Regiment, Companies and Diseases; this is agreeable to General Orders, my Instructions from Congress, the Director General and entirely agreeable to common sense.

The men of Colonel Hall's regiment were not refused admittance into the Hospital, by a certain Doctor Draper; as you set forth, because there were no Orderly Men sent with them; the Doctor only required the Serjeant who came with them to see them to the hospital, and (he) replied he would be damned if he did. You have pointed out to his Excellency the Regulations of Congress, respecting the Hospital Department and say from such Procedure, little Benefit has been derived to the Army. I know not what your Ideas of Benefits may be, but give me Leave to assure you that I have received into the Hospital 1100 Sick from the different Regiments since my Arrival in Camp and have disposed of them in such a Manner as I have been directed, and I can *aver* they have been properly taken care of.

You say that Surgeons have no Medicine or proper places to take care of the Sick. The Surgeon to Colonel Hazen's Regiment was at the Opening of the Campaign provided with as complete a Chest, as was ever sent into the Field, and he like an *attentive good officer* left it behind him this Morning in the Field. I picked it up, and sent it to the Hospital Tents, having no Waggon to bring it on; I hope you will take proper Notice of this Neglect and let the offender be brought to Justice. Sick men may Be taken Care of in Tents until they can be conveyed to Hospitals, if proper attention is paid to them by their officers or Surgeons.

I am sorry to inform you that your whole Charge is without Foundation, and you must, either have been imposed on yourself or your Intentions must have militated against the Reputation of Gentlemen who, I flatter myself, have paid as much attention to the Duty, of this department, as any Set of Men in the Army. I would not even except a *Major General*.

I must insist that *you* will write to his Excellency, withdraw your Charge, unsay every thing you have said, or I will take the necessary Steps to do myself, and the Gentlemen under my Direction that Justice every honest Man has a Right to expect.

I am Sir your Humble Servant
John Cochran

Strong words, indeed, from a Surgeon to a Major General, words which Sullivan could not take lying down. On July 5th he wrote the following two letters, one to Cochran, the other to Washington:

[Gen. Sullivan to Dr. Cochran, July 5, 1777.]

Pompton July 5th 77.

Sir

Your letter of yesterday was delivered me last night; at the contents of which I am much surprized: You say that my letter of complaint against the surgeons of the Hospital is before you & that whoever gave me the information is a stranger to truth & that it would have been well for me to have examined into the matter before I lodged the complaint. If you ever read my letter you must have seen that I began it by saying that Col. Hazen & Hall complain & I related the substance of their complaint and added not a word of my own, Except what was founded on that complaint: As for y^r advice respecting an Enquiry into the matter before I forwarded the complaint I never once thought it my duty to appoint a Court of enquiry to find out whether I ought to believe the complaint of two field officers before I sent forward the complaint to the Comm'in chief & as I am convinced it is no part of my duty I would not wish you to interfere in my department in future, by giving me advice, as I think I know my duty much better than y^r self — I know of no Authority I have to enquire into the truth of complaints tis enough for me to hear them and then forward them to H^d Quarters that a proper court may be instituted to enquire into the matter. You say that I pointed out to his Excellency the regulation of Congress & observe that little benefit is derived to the army from that procedure: There is no such thing in my letter: I say that we (meaning my own division of which I was then speaking) can derive little benefit from that procedure, if so many well men are to be call'd on to attend the sick: I have not been with the rest of the army & know nothing of their situation nor of the advantages they derive

from y^r care. It is true I said the regimental surgeons were not properly furnished with medicines or plans for the sick; This is undoubtedly a fact in General whatever may be the particular case of Col. Hazen's regiment or surgeon. I was too well acquainted with the resolutions of Congress to charge this as a fault to the surgeons of the G: Hospital nor is there anything in my letter that looks like it. You say my charge is without foundation & that I must either have been imposed on myself or my design must have militated against gentlemen who have paid as much attention to the duties of their department as any sett of men in the army not even excepting a Major General: when I began my letter by mentioning the complainants it is very surprising that you should suppose I had an intention to injure the reputation of the surgeons of the Gen^l Hospital, nor can I conceive that a charge made against one of them is to affect the whole. Indeed I shou'd be very sorry if it did for some of them stand very high in my esteem & I believe will never give just cause for a charge against them, while others may be liable to censure. If I am the Major General you alluded to in y^r comparison, I must tell you that you or they have not yet had it in your power to serve the American cause either in or out of the field, so much as myself, that is a fact known to whole Colonies in America and your running the Parralell only shews y^r ignorance of the fact you speak of. You insist upon my writing to His Excellency withdrawing the charge and unsaying everything I have said or you will take the necessary steps to do y^r self and the Gentlemen under y^r direction Justice. As to unsaying anything I have said or withdrawing the charge depend upon it I will not: If what you say afterward is intended as a threat I assure you Sir that it is so long since I have learnt to despise threats and threatners that I shall take no farther notice of it than to inform you that D^r Cochran or any other Persons who think themselves injur'd by me cannot find me at any time unprepared to defend myself or punish any insult that may be offered me. I am exceedingly sorry to say that y^r letter is calculated to insult me for doing what I know is my duty. I am therefore determined to know whether an officer in your station can be countenanced in insulting an officer in my station for having forwarded a complaint to his Excellency made to me by two field officers: I never before knew or ever thought that surgeons of the General Hospital were not as liable to be complain'd of as others & even if those complaints were groundless that they shou'd take the same means of redress after tryall as other officers. I promise you that whenever a complaint is made to me against them I shall not think their Persons or Character too Sacred to bring them to Tryall and to punish them if properly condemned. Upon the whole I think the good of the service wou'd be materially injur'd if I did not take proper notice of this surprizing procedure that I hold my self obliged to take the most effectual means of fixing the proper line between officers and their Power in the several departments. In the mean time I wou'd not wish to prevent you from pursuing any steps you may have in view. Whatever they may be 'tis impossible they can give the least Trouble to y^r Hum: Serv^t.

P:S: Whether there is any foundation for the complaints made you will soon Know.

[General Sullivan to General Washington]
Pompton July 5th 1777

My dear General

I do myself the Honor to Inclose your Excellency a Letter from Doctor Cochran to me with a Copy of my answer; as the Doctor's Letter was founded on a complaint I sent your Excellency I esteemed it my Duty to make it known to your

Excellency. When complaints are made to me I must take notice of them, or I must not; if the former is the case I must insist upon his Letter being an Insult of the most Dangerous Tendency — if the Latter is the case I shall be glad to know it that I may know how to conduct (myself) in future. The complaint of Hazen and Hall was made to me early, when my Division was on march, I had neither Time nor authority to appoint a Court. I at their urgent Request wrote your Excellency Supposing proper order would be given and the Sick which we were sending a second time would be properly taken care of — if Sir an Insult of this kind is to be suffered by a Major General for attending to and forwarding the Complaint of Two field officers commanding Regiments I should wish to Resign my commission that I may not by an Inconsiderate act Disgrace the Rank of myself and other general officers. I would not trouble your Excellency with this matter did it not appear to me a matter of Importance to others as well as myself — Since my arrival from New England I agreed to meet one officer of Inferior Rank at a Time & place he was pleased to appoint; for doing what? he upon the spot acknowledged was strictly my Duty, for this I was blamed by officers of my own Rank. I expect they said that Subalterns and Sergeants will next call me to account for Disapproving their Conduct. I am by no means an enemy of Duels & most sincerely wish that Congress had encouraged instead of prohibiting them but it is a Question well worth Consideration; whether if I forward a complaint against a surgeon of the General Hospital I must fight all the Sons of Aesculapius in Camp. If this is to be the Case I wish to be dismissed from the Business of my office that I may have the more Leisure on hand for the purpose and Stand on Such a Line as may not Disgrace myself and others, nor be accused of establishing a precedent in our Army known in others & which would effectually destroy all Distinctions of Rank and Superiority in Commission. I am awaiting easy what Steps Mr. Cochran may think proper to pursue or any other that think themselves Injured by my Conduct. I am always prepared to defend myself against personal Attack but think this an Insult of a such a Kind as to deserve publick Discussion and therefore take the freedom to apply to your Excellency for that purpose. Dear General I have the Honor to be with much Respect your Excellency's most obedient servant.

John Sullivan

His Excellency General Washington

In his reply Washington "regretted that the misunderstanding between you and Dr. Cochran should have gone to such disagreeable lengths," but he refused to become involved in the distasteful controversy. Instead the Commander in Chief suggested that a Court of Inquiry be convened, a measure that the impetuous Sullivan had already set in motion. The complete report of the Board is printed here for the first time:

Copy of a Court of Inquiry Ordered by Genl Sullivan July 6, 1777

The proceedings of a board of inquiry held at Pompton by order of Major General Sullivan to enquire into the conduct of the surgeon of the general hospital respecting the reception of the sick from his division.

Coll Gunby President
Capt. Thompson

Capt. Holland
Capt. Winder

Capt. Dorsey	Lt. Smith
Capt. Eccleson	Lt. Prince
Lt. Wilson	Lt. Smith
Lt. Morris	Lt. Monohan

Mem. A dispute arose relative to rank, which could not be determined, but the officers to expedite the business agreed to the above arrangement, at the same time it is by no means to be drawn into precedent; so as to affect the rank of any officer when it comes to be ascertained.

(Doctor Tillotson) of (Col. Hazen's) Regiment being sworn — deposeth — That a day or two after the regiment was posted on the mountain near Middlebrook, he informed Col. Hazen that several men were unable to march, who directed him to send them to the flying Hospital, which order he should instantly have complied with, had he not been baffled in several applications for waggons until towards evening, when he sent them off with a return of their names and the companies they belonged to, taking no notice of their complaints, of which he thought the physicians of the hospital ought to be proper Judges; but was much surprised to seeing them return about sunset with a letter from (Doctor Cochran), a copy of which follows this Disposition.

That the regiment were stationed in a wood, and had received orders not to pitch their tents, in consequence of an expectation to march the next morning; so that the sick were obliged to be out that night, exposed to an hard and constant rain, which did not intermit until about one O'clock the next day; as soon as it did so he again dispatched the sick to the hospital, with such a return as is mentioned in Doctor Cochran's Letter, who then received the whole of them (probably made proper objects for an hospital by the rain which had fallen on them) and told the mate who was with them, that the return was wholly non-necessary; as the mate informed the deponent. That the day after the deponent's Mate sent one or two sick to the Hospital; with a like return to that sent with the sick who were not received, whom Doctor Cochran (adhering to his great uniformity of conduct) received

(William Tillotson)

Sir

You have sent a number of men belonging to the Regiment of which you are Surgeon, without any return of the names or diseases. Please to look at the resolves of Congress, and the general orders, and you will find that proper returns are to be made when you send men to the hospital. Many of them, I am sure, are not proper objects for an hospital, and can very well be kept in camp, and the greatest Justice done them.

At seven O'clock in the evening, is a very improper time to send sick to an hospital, especially where there are no accommodations for them in less than 16 miles. When they are sent at a proper time of day, and a proper return sent with them, I shall dispose of them in a proper manner.

I am Your humble Srvt
John Cochran

Middlebrook Camp
June 29th 1777

(A copy)

Serjeant Wand (who was recommended to the Court by his officers as a person of credit, and who appeared to the court to be very intelligent) being sworn deposeth — that he went

with the sick to Doctor Cochran, who appeared to be very angry, said that it was not a proper time to send them, that he had no accommodations for them that night, and declared he would arrest the next Physician who should send sick to the Hospital again like manner; — that Doctor Cochran said he supposed Doctor Tillotson had taken the return sent with the sick from the report of the orderly serjeant, without examining their disorders, and asked the witness if there were any clerks in the Reg^t — The Deponent informed Doctor Cochran, that he had seen Dr. Tillotson examine the sick himself; that when the sick were about to return; Doctor Cochran delivered a message to the deponent for Doctor Tillotson, which he refused to carry, it being too insulting to be delivered to any gentlemen, that Doctor Cochran then wrote the above Letter, which he read to the deponent, and which was couched in much milder terms than the message given to the deponent, observing that it was not very harsh.

Ja^a Wand

(Doctor Ridgely) being sworn deposeth — that whilst General Sullivan's division were on the mountain, orders came out one evening for the Reg^t to which he belonged, to prepare to march the next morning, which induced him to give notice to (Col. Hall) that there were some men unable to go forward. Col. Hall directed him to send them immediately to the — Hospital, which he did under the care of (Serjeant Young) with a return, fixing their names, the company and the Regiment they belonged to. — That the sick were returned to him that morning after dark — When their Regiment marched, some of the sick were got into waggons, others were obliged to get forward as well as they could, and a few were still absent from the regiment. That as soon as the Reg^t encamped near MorrisTown, he sent of his sick again to the Hospital there, with positive orders to the Serjeant to leave them, if they were refused at the door; where they were at length taken in, after being frequently refused, and in consequence of much altercation, as the Serjeant informed the doctor The Deponent believes it rained the evening the sick men were refused at the hospital of Middle Brook, but is sure it was on the same day Doctor Tillotson sent his; and it is his firm opinion, that several of them will loose their lives in consequence of that refusal

(Fred^k Ridgely)

Serjeant Young being sworn deposeth — That he went with the sick sent by Doctor Ridgely to the Hospital at Middle Brook, and when he came, saw a Physician of the Hospital, a low, redfaced, pock marked, sharp spoken man, to whom he delivered the return sent by Doctor Ridgely containing their names and the companies they belonged to, on which the Physician ordered the men out of the wagon, and directed them to sit down until he could have tents pitched for them; he then asked for the well man — what well man answered the Deponent, the well man to attend the sick replied he — the deponent returned, we do not send well men to an Hospital, we want them in the Reg^t — He then swore he would not receive the sick without people to attend on them, ordered them into the waggon again, gave the return back to the deponent, and sent him with the sick to the Mountain

(Benj^a Young, Serj^t)

(Col. Smith) being sworn deposeth — That he happened in company with (Doctor Draper,) of whom he asked the reason of the sick of the 4th Maryland Reg^t being refused — admittance into the Hospital; Draper made answer that they came when almost night, that had he received they must have laid on the ground, as all their tents were full, that he desired the Serjeant to remain with and take care of the sick, who refused staying, and that his principal reason for refusing to

receive them was that no proper return was made; Col. Smith then told him that Doctor Ridgely (who sent the sick) had been last year in the general Hospital, and would not send sick without a return, Draper assured him there was no proper return, for said he, what was the reason I received (Col. Stones?) because (answering himself) his surgeon sent a proper return. — That Doctor Cochran was present and bore a part in the conversation, and told the deponent, that he must not think the business of the Hospital was conducted in the same manner it was last year; to which the deponent replied, that true it was not, for that last year the sick were received and suffered to die in the Hospital, but that this they were not received at all.

(Sam^l Smith Lt. Col.)

(Serjeant Smith) (who with Serjeant Young is of the 4th Maryland Reg^t, received with Young a strong recommendation from his officers, and both appeared to the court to give their testimony with caution and veracity) being sworn deposeth — That they went with the sick sent by Doctor Ridgely to Morris-Town, and when he came to the Surgeon and offered them to him, who absolutely refused to take them in, asking if this was a proper time to send sick to an hospital, to which the witness answered, that they could not be sent sooner, as the Reg^t had encamped late in the Evening.

That the Doctor said this was the 3d time Doctor Ridgely had sent returns of the sick to the hospital that day, and ordered the serjeant to take them back, for that if he left them they might stay on the green, however as the Deponent had orders from Doctor Ridgely to leave them, he refused to do so, That the Doctor threatened to have the witness punished for his insolence (as he termed it) in refusing to carry the sick back — After this Dispute had continued for some time with one of the surgeons, another came up who went to the nurse, enquired if she had room for any more sick, and being answered in the affirmative, received those the deponent had under his care. The Deponent does not know the name of either of the Physicians.

(Wm Smith Serj^t)

(Doctor Tabbs) being sworn deposeth — That the day before General Sullivans Division marched from the mountain near Middle Brook, by order of (Col. Gunby) he sent three sick to the Hospital with a return of their names and the companies they belonged to; one of whom who had the venereal disease was sent back, being ordered, as he informed this deponent, to go to the damned Bitch who gave it to him, and get cured, — That the man failed on the road and is now lodged in the hospital at Morris-town

(Barton Tabbs)

(Doctor Marshall) being sworn deposeth — That a day or two before the division marched he was directed by (Major Stewart) to send the sick to the hospital, which he did, with a return of their names and the companies they belonged to, who were returned the next morning with the Letter which follows this deposition. — That several of the sick were down with other disorders besides venereal and yet were returned, altho' unfit for duty, without any reason being assigned for it.

(W^m Marshall)

Sir

We never receive into a general hospital any patients who have simple claps — A Little Physick and proper care will soon relieve them I do not know of (Thomas Summers) and

(Henry Lynch) being in the Hospital till this morning, — otherwise should not have admitted them. They ought to be put on light duty and will receive no injury from it.

I am your humble servant
John Cochran
Surg^t Genl

Middle Brook June 30th 1777

These men complain that they have been long ill & have no medicine. I could wish that no complaints of this kind may happen in future —

(A Copy)

A true Copy from the minutes of the Court
(John Taylor. I.A. pro occasione)

John Gunby
President

Washington Papers Library of Congress

One cannot help but notice the obviously biased testimony of the regimental personnel and the fact that the Hospital surgeons were not represented at this packed court. It is pleasant to learn that no action was taken against the doughty Cochran, whose successful career I have described elsewhere.** Instead Sullivan learned not to interfere with the Hospital when the following General Order was issued: "No patient was to be ordered from the General Hospital by an officer of the regiment to which he belongs or presume to leave it himself, until he obtain a regular discharge from the Senior Surgeon or Director of the Hospital." Furthermore no charge for "private support or medical attendance" could be authorized unless "from the returns reasonably made it would appear that the sick could not receive the benefit of a general hospital."

However, in all fairness to the line it should be noted that it soon became obvious that the general hospitals, as then constituted, could not possibly accommodate all the sick. Probably acting on the advice of the pragmatic Cochran Washington ordered:

"The General finding the number of sick to increase, and being desirous to have them as well accommodated as possible, directs that the Barrack Master under the direction of the Col. or Commander Officers of each regiment fix on some house convenient to the regiment to be improved as an hospital for the reception of patients first taken down, or where disorders do not require special assistance beyond that of their own regimental Surgeons. One of the surgeons of the hospital will occasionally visit these hospitals and determine

***Surgeon to Washington: The Life of Dr. John Cochran—1730-1807.* New York, Columbia University Press, 1977.

when the nature of the case requires the patient to be removed to the general hospital, which will be kept in different houses contiguous to the Brigade. The Regimental Surgeons are to receive directions from and be responsible to the director General so far as respects the furnish their Regimental Hospitals with conveniences for their sick. The order of 28th July respecting the removal of the sick from the regimental to the general hospital having been misunderstood by some, the General directs that it be taken with the following explanation. The Regimental Surgeons are to send at any time with the usual ticket any patient to the General Hospital whose case requires it (putrid and infectious disorders always excepted). Whenever the Director Gen'l or any surgeon of the hospital by his direction visits the Regimental Hospital they are to direct what patients are proper to be removed, but it is expected that when any surgeon visits the Regimental Hospitals he will consult with the Regimental Surgeons, and if they should differ in opinion they will refer it to the Director Gen'l who has by the resolution of Congress a superintendency over the whole. The General most earnestly recommends to the gentlemen in both departments to cultivate harmony and good agreement with each other as conducive to their own honor and the good of the service."

We can now see that the battle described here ended in something of a draw. If the regimental hospitals were not entirely eliminated, the Head of the General Hospital had successfully

asserted his full authority to inspect them and supervise activities of their surgeons. I do not intend to overemphasize the importance of the Sullivan-Cochran encounter in New Jersey but, for the historian of medicine, the incident is not without significance. Following the British tradition, high-ranking Revolutionary officers including General Charles Lee refused to accept medical men as full equals, and it was for this reason that such well-trained surgeons as Generals Hugh Mercer and Arthur St. Clair preferred to serve with the line. Furthermore, even Congress took an inordinate length of time to grant the medical staff the same emoluments previously granted to field officers. Freedom-loving men like Cochran could not tolerate such a position of inferiority, and his letters are replete with statements of indignation on the subject. To his credit it should be noted that it was not until his Directorship (1781-3) that the medical officers in the Army of the United States finally did attain the full equality of status they had so long sought in vain.

292 Paulison Avenue, Passaic

Festival of the Ten Crucial Days

The New Jersey Bicentennial Celebration Commission is preparing a gala Bicentennial "Festival of the Ten Crucial Days," which will begin on Christmas Day with the 200th anniversary of Washington's Crossing of the Delaware and run through January 3 with the re-enactment of the Battle of Princeton. Also commemorated by re-enactment will be the First and Second Battles of Trenton on December 26 and January 2. Volunteers from Revolutionary War Re-enactment Units in New Jersey and 17 other states will participate as American, British, and Hessian troops.

There also will be a series of major cultural and artistic events throughout the ten days, including performances by the Greater Trenton Symphony Orchestra, the Newark Boys Chorus, the Princeton Ballet Company, the New Jersey Ballet, the Pro Arte Chorale, and the New Jersey Opera. Scheduled, in addition, are an ethnic fair, a film festival, a three-day Youth Constitutional Congress with representatives from New Jersey high schools participating in a discussion of the American Constitution and its future, entertainment for children, exhibits, and a symposium entitled "Winter of 1776" with a panel of leading historians who will comment upon the effects of "the ten crucial days" on the thirteen original colonies.

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***Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500, 1000, 5000 and Unit Dose.

Diabetes Education — Needs for the Patient and Professionals*

T. Franklin Williams, M.D., Rochester, New York

Education for the diabetic patient is obviously necessary. However, few health professionals or patients have considered the need for diabetic education important enough to do a really good job of it. It may seem so obvious that we often forget that the patient has to play the key role in managing his own disease. In diabetes, more than almost any other disease, proper therapy consists of day-by-day or even hour-by-hour, attention to, and balancing of, two of the most basic aspects of living — food intake and physical activity. To this is added the importance of careful daily care of the skin, especially the feet; the daily administration of insulin or oral drugs; testing of urine; and the ability to deal with potential emergencies.

In a year, the average patient spends 5,800 hours awake. Barring an episode of major illness, the patient will have direct contact with the physician and his colleagues for no more than six to twelve of those hours. So what goes on in all of the essential aspects of diabetic therapy depends almost entirely on what the patient or his family does. The physician, nurse, or nutritionist, by contrast, has only relatively brief, periodic opportunities to influence the ongoing management of a patient's disease.

Thus, health professionals who are trying to help the diabetic should concentrate much of their efforts on helping him learn how best to self-manage. And the chance of success for the therapeutic regimen developed by the health professionals depends upon the degree to which the patient and his family carry out the recommended regimen.

What the Diabetic Needs To Know

The diabetic needs to know what diabetes is. He should be told what is known about causes — heredity, overweight, or unusual causes. He should be aware of the chronic nature of the dis-

ease. He must know what constitutes adequate control. And, he should know the danger signals of complications.

To self-manage, the diabetic must know about what and when he should eat, as well as reasons for food restrictions. He needs to know about the importance of exercise and the relationship among physical activity, food, and insulin. He should be knowledgeable about the medications he is taking, about all aspects of urine testing and skin and foot care, safety measures (like carrying identification, sugar) and glucagon. There should be a continuing working relationship between the patient and the health professionals — physician, nurse, nutritionist. And the diabetic should know how to get help in an emergency.

How much do diabetics actually know about their disease? A number of studies have been carried out in which questionnaires about diabetes were administered to diabetic patients and the parents of diabetic children. The relatively simple questions dealt with material any diabetic should be expected to know.

In one early study of a large group of adult private patients all were deficient in some area of knowledge. In a study of parents of diabetic children, conducted by Donnell D. Etzwiler, M.D., Director of the Diabetes Education Center, Minneapolis, only 65 percent passed. Among adult patients in private practice in North Carolina, only 65 percent passed. Only a third of the adult patients passed a simple test in three university diabetes clinics in North Carolina. Similar results were obtained in a study of university

*Presented at the Conference on Diabetes Education and Management, March 1975, Rutgers Medical School, CMDNJ, Piscataway. Dr. Williams is Professor of Preventive Medicine, University of Rochester School of Medicine.

clinic patients in Iowa. In each of these studies, the gaps in knowledge occurred in *all* of the topics summarized above.

Next, the patient's performance of recommended management procedures was assessed by actual observation. The following results were obtained primarily from studies done in North Carolina, but examples can be found in other studies as well. The patients come from a variety of backgrounds.

In the field of diet, under direct daily observation, 65 to 90 percent of the patients studied showed major deficiencies in their knowledge of food selection, in terms of poor nutrition, use of food inappropriate for diabetics, improper spacing of meals or snacks, and irregular mealtimes.

Nearly 60 percent of the patients taking insulin made errors in the use of the drug, including incorrect dosage, and improper measurement technique. Among patients taking oral hypoglycemic agents, 25 percent omitted doses at least once a week. Furthermore, the frequency of medication errors increased with the duration of the diabetes, thus emphasizing the importance of long-term repeated instruction.

In the first five years after diagnosis of diabetes, 25 percent of the patients studied made errors in their insulin measurements or insulin dosage. Such errors increased progressively. In patients who had diabetes more than 20 years, 80 percent were making errors in their insulin dosage.

Three-fourths of the patients studied did not test their urine, record the results, or made errors in recording or reading the tests. Their physician or nurse received misleading information about their urine test results.

Even in foot care, which might be considered one of the simpler and most important areas for the diabetic, half of the patients did not carry out minimally acceptable foot hygiene.

Considering all these data, fewer than one patient in ten was carrying out a minimally adequate regimen in all of the areas we consider important in diabetic management. That means, nine out of ten were in trouble in one or more of

these areas. So, health professionals face an enormous problem in trying to achieve more effective knowledge about diabetes among patients and more effective efforts by patients to carry out good management.

Why Diabetics Don't Know

What may account for these poor results in educating and motivating patients? In the first place, there is evidence that relatively little effort is invested in diabetes education, for both patients or professionals. For example, in a study of the 26 hospitals in the Minneapolis area, Etzwiler found that only three had budgeted funds for patient education in diabetes or any other disease. In 12 of the 26, a specific staff person was identified as responsible for educational programs for patients. But again, most of those didn't have a patient education budget. Fifteen out of the 26 had purchased some type of educational materials in the past year, but 11 had purchased nothing.

A recent nationwide study conducted by the American Diabetes Association's Committee on Diabetes Education Centers found only 34 settings in this country in which there existed organized programs for diabetes patient education. That's probably an underestimate, but even if that figure is doubled, it represents a tiny fraction of the hospitals, clinics, and other settings around the country where diabetes education should occur.

Further evidence of the lack of professionals available for diabetes teaching is the fact that although a trained dietitian is an essential member of the diabetes teaching team, a review of all the Minnesota general hospitals in 1967 revealed that only half had a trained dietitian on their staff.

Secondly, physicians, nurses, and dietitians that come in contact with and should be teaching diabetic patients are often less than adequately informed about diabetes themselves. In a recent study, Etzwiler found that senior nursing students from six schools of nursing answered many basic questions *incorrectly* on a relatively simple test about diabetes. Not only don't the patients know, but neither do the health professionals.

For example, eight percent of the nursing students didn't know that insulin causes a blood sugar to decrease. Thirty-five percent did not know that less insulin is needed when exercise is increased. Forty-four percent didn't know that a diabetic patient should continue his insulin when he feels ill and cannot eat. Less than 50 percent understood the principles of the diabetic diet, including the fact that a proper diet for a diabetic person is also a well-balanced diet that any member of the family can eat. Hospital dietitians, including those with presumably adequate training performed no better on the same questions than did the senior nursing students.

There are no comparable data about physician knowledge about diabetes. However, in the same report, Etzwiler described a followup of 89 persons who were found to have an elevated blood sugar in a diabetes detection drive. In 17 instances, or about 20 percent of the cases, the patient's physicians either did not carry out follow-up studies, or took what is generally regarded as inadequate steps for evaluation or treatment.

A third factor in why we have this problem in patient performance is that the characteristics of diabetes itself can tend to work against continuing motivation for the diabetic patient or his teachers. For example, in the case of the juvenile-onset, brittle diabetic patient, no matter how much the patient learns, he still has problems in day-to-day management. We simply don't know enough about the disease yet. We don't have adequate treatment procedures to solve all the problems of brittle diabetes.

On the other hand the patient who has adult-onset, mild, and relatively stable diabetes may find that relatively minimal measures of management are usually sufficient to eliminate any symptoms related to the disease. The patient's attitude is, "Why bother anymore?"

Health professionals working with diabetic patients often do not know enough about what the patient is actually doing correctly or incorrectly in his day-to-day management, and thus may waste teaching efforts on areas in which the patient already is performing adequately. By failing to correct, the health professional may

even perpetuate ongoing mistakes in the patient's knowledge or management.

Professionals and patients often have conflicting goals. Professionals are interested in controlling diabetes, while patients are interested in knowing more about the disease and in having good relationship with a physician and other professionals whom they can trust. One problem that the "contract" approach addresses directly is the development of a common understanding of what the goals of management are, with input from both patient and health professional.

Finally, there are inadequacies in types and availability of teaching materials. Until recently there were no teaching materials specifically designed for illiterate persons, or even for persons with less than a high school level reading comprehension ability, even though a large proportion of our population falls below this level. There were few materials in the United States in any language other than English. A number of efforts to remedy these deficiencies and others are underway, but much remains to be done.

One goal that the American Diabetes Association's Committee on Diabetes Education Centers hopes to realize is the publication of a handbook on the education of the diabetic patient. This guide is designed for people who teach diabetes in all types of settings.

Meeting the Patients' Needs

First, there is a clear need for more attention to and preparation for educating diabetic patients by physicians, nurses, and nutritionists, in all types of settings.

Second, planned systematic diabetes patient-education programs should be required in all health care settings. And patients should be required to participate in the educational activities. The point should be reached where not rendering patient education in diabetes would be considered a deficiency in service or even a potential liability.

Coupled with this, of course, is the necessity that there be reimbursement mechanisms which

recognize patient education as a legitimate cost of health care. Until now, virtually all patient education in diabetes has had to be paid for through the physician's bill or the hospital's total per diem reimbursement. Almost never, thus far, has it been written into a health maintenance organization contract or any other type of prepaid care plan.

Third, there are some principles that should be considered as a part of a broad educational effort. It is necessary to assess where the patient is — i.e., the current levels of his knowledge and performance in carrying out regimens. We've got to remember not to start over every time; education is a continuing process.

It is important to determine the needs and preferences of each individual patient, in terms of daily activities, food preferences, and other aspects of patient or family lifestyle. We have to recognize that some of the daily habits and lifestyles change — especially eating and physical

activities. We need to mold our plans to what the patient is doing as much as possible, rather than try to mold the patient to an arbitrary type of outline that we may have in our books.

We should consider the desirability of contracts, the agreements between the health team teachers and the patient. We ought to make changes in small steps and undertake teaching as a health team of physician, diabetes nurse specialist, and nutritionist.

Finally, I again stress the importance of an ongoing educational effort and continuing supporting relationship with the diabetic. Studies have showed that when this sort of relationship occurs, better patient performance results. Even though a one-shot, intensive teaching program for diabetics may be useful at times, it cannot take the place of an educational program that is an ongoing one and maintains a supporting relationship between the health professionals and the patient.

University of Rochester School of Medicine,
Rochester, New York

Responsibility for Reporting Theft of Controlled Substances

The Drug Enforcement Administration (DEA) wishes to remind physicians of their duty to report all thefts of controlled substances to the nearest DEA Office. Title 21 of the Code of Federal Regulations, Section 1301.74 requires the registrant to notify the Drug Enforcement Administration of any theft of controlled substances immediately upon discovery. DEA's form 106 should be used for reporting a theft or loss. This form not only serves to notify the DEA but a copy retained by the physician is his official record to account for the disposition of

the controlled substances. Without this form, the physician may be held responsible for undocumented losses.

Copies of the DEA-106 may be obtained from the Drug Enforcement Administration office in Philadelphia (600 Arch Street, Room 10224, Philadelphia, Pennsylvania 19106, telephone 215-597-9540).

NB: A supply of the form also has been made available to MSNJ (Journal office).

Journal Clubs

The journal club, a traditional method of continuing medical education, has had a renaissance among physicians, within and without hospital staff organizations, in recent years. The apparent stimulus for this renewed interest has been the desire to "review the literature" in preparation for certification and recertification examinations by some and the longer-range potential of relicensure by others. Unfortunately, case histories of recently developed "clubs" describe short, chaotic existences with abrupt termination. An autopsy of one such study alliance revealed poor attendance, lack of leadership, and a disinterest on the part of some members in reports dealing with subjects out of their special field of interest. Frustration among the stable membership was too much to allow the patient to survive.

A journal club is an organization of physicians or medical students which meets at regular intervals to review and discuss scientific journal articles. The general purposes of a "long term" or perpetual group is to keep abreast of the literature in one's own field of interest and to become aware of the writings in other generic fields of medicine. The "short term" or "special" journal club should be developed for a specific purpose, i.e., to prepare for licensure examination or for re-examination, recertification, or even relicensure. Once the special purpose is accomplished, this type of club is disbanded.

Participants in an in-hospital journal club may consist of the house staff (interns, residents, fellows, and medical student clerks), members of individual departments or the entire medical staff. Outside the hospital setting, such organizations tend to be made up of a selective group of friends who use this device as a combined educational and social gathering. The conduct of a journal club is generally rigidly structured with regular meetings at specified intervals, time limits, a moderator, and rules of discussion. There are usually one or two "presenters," specified journals, and selected articles which have been abstracted for the meeting.

Journal clubs have some intrinsic and extrinsic problems to contend with and these may lead to misuse or abuse. It is not cricket for the presenter to use "canned" medical abstracts from the many sources which are readily available. "Audio-digest" and other recorded medical abstracts, panel discussions, and interviews are inappropriate as a basis for the traditional journal club. Journals themselves may be a potential source of problems since certain types — state and county journals and "throw-away" journals (a colloquial term which in no way implies disrespect, since many of these magazines are superior in quality) — are generally not acceptable. The unavoidable lag time from submission of manuscript, rewriting and editing, and ultimate publication means the material has aged nine to twelve months from its author's pen to the reader's eye.

Scientific accuracy of articles varies with the integrity of the writer and the care with which the journal's manuscript reviewers and editorial staff evaluate them. It is a fact of life that authors and journals rarely retract or correct inexact data or misjudgments of opinion after they originally appear in print. Thus, the journal club communicant may, in fact, be misguiding his colleagues unintentionally.

The journal club is mainly beneficial to the homogeneous group such as the residents or fellows in a specialty or members of individual departments. The technique can, in fact, keep such members abreast of their own literary field, but it can also increase the expertise of the reporter in the techniques of abstracting and scientific articulation.

The moderator becomes adept at leading the group and maintaining discipline, but he must provide academic stimulation as well. The participants in a journal club gain the most if they remain attentive and actively participate in debate and discussion. Somnolence is deadly!

In the end, the keys to success of a journal club are quite clear. The moderator must be a

knowledgeable and stimulating spark plug. The group must have a specified purpose. Although membership should be voluntary, homogeneity works best. Attendance should be required, meetings ought to be held at regular intervals, and journals are to be assigned. There must be a strict limit as to the number of papers (about four) and time (approximately twenty minutes

per paper). The communicator must be selective and well prepared.

Finally, don't forget to record your hours! You get Category Five CME credits — up to 22 credit hours — for participation in journal clubs.

A.K.

INFORMATION FOR READERS AND CONTRIBUTORS

The Journal, the official organ of The Medical Society of New Jersey, is published monthly under the direction of the Committee on Publication. *The Journal* is released the first week of the month, and a copy is sent to each member of the Society.

Change of Address: Notice of change of address should be sent promptly to The Medical Society of New Jersey, P.O. Box 904, Trenton, New Jersey 08605.

Communications: Members are invited to submit to *The Journal* any suggestions for the welfare of the Society, as well as comments or criticisms of material in *The Journal*. All such communications should be directed to the Editorial Office of *The Journal*. The Publication Committee reserves the right to publish, reject, edit, or abbreviate all communications submitted.

Contributions: Manuscripts (original and one copy) submitted to *The Journal* must be typewritten, *double-spaced* on letter size (about 8½ x 11 inch) paper, and forwarded to the

Editorial Office at the address below. The Publication Committee expressly reserves the right to reject any contributions, whether solicited or not, and the right to abbreviate or edit such contributions in conformity with the needs and requirements of *The Journal*. Galley-proofs of manuscripts will be submitted to authors for correction of typographical errors. Rewriting or reinsertion of material changed or deleted by the editor is not permitted. Every care will be taken with the submitted material, but *The Journal* will not hold itself responsible for loss or damage to manuscripts. It is understood that material is submitted here for exclusive publication in this *Journal*.

Illustrations: Authors wishing illustrations for their articles will submit glossy prints or original drawings.

Bibliography: Format used in JAMA must be followed. References should be numbered in order of citation in the text.

Reprints: Reprints may be ordered after the author has been notified that his article has been selected for a specific issue of *JMSNJ*.

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

P.O. Box 904, Trenton, New Jersey 08605

NEW JERSEY DOCTORS' NOTEBOOK

Trustees' Minutes

October 17, 1976

A regular meeting of the Board of Trustees was held on Sunday, October 17, 1976, at the Palisadium, Winston Towers, Cliffside Park, New Jersey. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

Public Relations' Expenditures . . . Decided not to use the professional liability investment income to cover the \$50,000 deficit accrued in carrying out the Board-approved, accelerated public relations campaign in the areas of professional liability, medicaid, delivery of health services, new physicians' interest in MSNJ, and physician participation in MSNJ, and referred the item to the Committee on Finance and Budget to be considered in conjunction with the budgetary proposals for the Council on Public Relations for 1977-1978.

AMA Conference on Rural Health . . . Authorized attendance (with expenses paid) of the Chairman of the Council on Public Health (Frederick P. Steller, M.D.) at the AMA Conference on Rural Health, March 30 to April 1, 1977, in Seattle, Washington.

Conference of Presidents and Presidents-Elect . . . Agreed that two meetings of the Conference of Presidents and Presidents-Elect will be scheduled prior to the end of April — one meeting of the group itself and one meeting with the Board on a Sunday other than one regularly reserved for the Board of Trustees' meetings.

Marsh vs. New Jersey Department of Health . . . Endorsed the action of Dr. Todd and Mr. Maressa who met with counsel for Dr. Marsh and agreed, upon receipt and review of the prospective pleadings, that MSNJ would enter the case (which concerns a certificate of need application for a CAT scanner) as amicus curiae (see *JMSNJ* 73:998 (November) 1976).

Swine Flu Immunization . . . Approved the following recommendations of the Council on Public Health concerning an appropriate influenza vaccine program:

1. For high-risk patients, defined as those who are 65 years of age and over as well as those who may have the following chronic diseases: heart disease of any etiology, particularly with mitral stenosis or cardiac failure; chronic bronchopulmonary diseases, such as asthma, chronic bronchitis, cystic fibrosis, bronchiectasis, tuberculosis, and emphysema; chronic renal failure; diabetes mellitus and other chronic metabolic disorders; chronic neuromuscular disorders; and malignancies and immunodeficient states.
2. For high-risk persons ages 3-24 years, we recommend a second shot of the swine flu vaccine not less than 4 weeks after the initial immunization. High-risk persons ages 3-24 years should also receive Influenza-B vaccine in a single dose as in the past.
3. The pregnant woman who is in a high-risk category should be immunized.

Medical Defense and Insurance . . . Approved the following recommendation from the Committee on Medical Defense and Insurance:

That the Board of Trustees offer both major medical coverage and major expense coverage to the membership of MSNJ and allow the physician to make a decision on an individual basis.

Tenure of Executive Director . . . Approved a recommendation of the Committee on Long Range Planning and Development that no change be made in current policy concerning employment of the executive staff.

Ad Hoc Committees . . . Approved the following recommendation from the Committee on Long Range Planning and Development:

That the chairmen of the Society's councils and committees have the authority to appoint consultants to serve on their councils and committees whenever it is felt that the council or committee lacks specific expertise in those areas which are not established within the current structure of the Society.

Note: The above resulted from a recommendation (4/14/76) to the Board that consideration be given to the appointment of ad hoc committees in lieu of special committees, which meet infrequently and do not cover all areas requiring study.

Admission of Osteopaths to MSNJ . . . Approved the following report and recommen-

dations of the Special Committee to Study Admission of Osteopaths:

Legal Aspects

1. The State Board of Medical Examiners has no concern with society memberships.
2. In order to enable doctors of osteopathy to be members of The Medical Society of New Jersey, it will be necessary to amend the Society's Constitution and Bylaws. The Committee suggests that the Constitution and Bylaws be changed to read:

Also eligible for membership are licensed physicians other than M.D.s who have had an AMA internship or residency or have a staff appointment at an allopathic hospital.

Practical Aspects

1. It is the feeling of the Committee that of the less than 1,000 osteopaths in the State of New Jersey, those interested in joining The Medical Society of New Jersey will have very little impact and probably will be limited to those closely associated with allopathic hospitals.
2. The Committee also feels that The Medical Society of New Jersey should continue the cordial relationship with the New Jersey Association of Osteopathic Physicians and Surgeons in matters of mutual interest, and that the Society has no intention of actively soliciting members from the New Jersey Association of Osteopathic Physicians and Surgeons.

Actuarial Aspects

1. As of September 3, 1976, the Joseph A. Britton Agency predicted that there will be no immediate effect on "premiums."
2. In view of the completely unpredictable situation in this field, as of October 3, the Committee feels that this situation must be re-evaluated immediately prior to any action by the House of Delegates.

Recommendations:

- (1) That doctors of osteopathy be admitted to membership in The Medical Society of New Jersey.
- (b) That the Society's Constitution and Bylaws be so amended.

Atomic Energy Plants . . . Approved the following report of the Ad Hoc Committee on Atomic Energy Plants which had been formed to implement Resolution #40 of the 1976 House of Delegates:

The Committee plans to address itself to the following issues:

1. Transportation of radioactive materials — this will include transportation of materials to be used as fuel, as well as waste products;
2. Local storage of fuel and waste materials — how and where;

3. Operational plant safety — dangers to the community with regard to radioactive core melt down, and dangers to the employees in the general daily plant operations;

4. Appraisal of the article written by John W. Gothman, M.D., *The Plutonium Controversy*;

5. Appraisal of the *Reactor Safety Study* conducted by Professor Norman C. Rasmussen, for the United States Nuclear Regulatory Commission in October 1975;

6. Environmental impact — comparison of conventional coal-operating plants to a nuclear-powered plant. The Committee decided that, since the use of oil as a fuel will, for all practical purposes, soon be phased out, study was not necessary on its long-term effects on the environment;

7. Locations for nuclear sites — underground, off shore, and above ground;

8. Better understanding of what the actual hazards of radiation exposure to the human body are — degree of dosage and long-term exposure;

9. Evaluation of guidelines to be followed in the event of an emergency occurring at the power plant — notification to the public, evacuation, and medical care.

All were in agreement that a statement on nuclear power plants could not be made by this Committee solely from review of the materials available. Experts, both for and against the development of nuclear power plants, must be consulted.

A meeting will be scheduled to which experts will be invited to address the issues previously listed. Speakers will be recruited from the following:

United States Nuclear Regulatory Commission
Public Service Electric and Gas Company
New Jersey Department of Environmental Protection
Union of Concerned Scientists

One representative from each of those contacted will provide two speakers for the development of atomic energy plants and two speakers against such development.

The date for the meeting, which will be held at 10 am on a Wednesday will be chosen by the Chairman, following receipt of replies from the speakers. Following the speakers' presentations, the Committee will convene for a general meeting at which time consideration will be given to the position statement to be submitted to the 1977 House of Delegates.

Recommendation: That the Board of Trustees authorize necessary expenditures *up to \$500* for the meeting of the atomic energy experts. (*Italics indicates amendment by the Board of Trustees.*)

Medical Director for MSNJ . . . Approved the following recommendation of the Ad Hoc Committee to Study a Medical Directorship for MSNJ (whose conclusion was that "there is no overriding reason for entertaining a physician as a staff person to the Society at this time"):

That the following strategies be considered in lieu of the Medical Directorship:

1. That candidates for presidential offices should be selected primarily on the basis of ability and competence.
2. That some reorganization and delineation of the duties of the present presidential officers should be considered.
3. That all of the presidential officers should increase their activities in ceremonial and other delegated official business of the Society.
4. That the Special Committee on Long Range Planning and Development consider the recommendation of including the duties of the Secretary of the Board of Trustees with those of the Secretary of the Society.
5. That the President serve also as the Chairman of the Board.
6. That consideration be given to a Bylaw change to permit the President to succeed himself to a second term.
7. That the President and the Executive Director have the authority to commit the Society to a decision in an emergency.
8. That the Executive Committee be structured to include the Immediate Past-President.
9. That the Executive Committee meet on a regular basis to discuss, as a group, the responsibilities and duties of the presidential officers.
10. That compensation for the presidential officers be reconsidered and be made commensurate with the time and effort demanded of the President (i.e., per diem compensation).

... Referred the findings of the Ad Hoc Committee to the Committee on Long Range Planning and Development, in consultation with the Executive Committee, for report to the Board within two months.

Medicaid committee ... Directed that a request from the Medicaid Committee for funding for public relations purposes be referred to the Council on Public Relations for report to the Board at the November meeting.

Cardiopulmonary Resuscitation Certificate ... Approved the following recommendation from the Council on Legislation which had been directed by the Board to draft appropriate legislation to request that all lifeguards be trained and certified in CPR:

That the Special Committee on Emergency Medical Care obtain a more definite and clear concept as to who would be granting certification in the instruction of CPR. The Council believes certification and instruction is necessary but that it is not a matter for legislation by MSNJ, and more properly belongs in the field of Public Health Education. The Council

on Legislation recommends that all the facts be gathered before MSNJ proceeds further.

Legislation ... Approved the actions taken by the Council on Legislation concerning bills referred back to the Council by the House of Delegates. The following is quoted from the Transactions as contained in *The Journal* 73:Tr 126 (August) 1976 and indicates the recommendation of the Reference Committee; the results of the recent reconsideration by the Council are indicated in italics

S-910 (Supplemental #1, page Tr 60) From "No Action" to "Disapproved."

No Action

S-1006 (Supplemental #1, page Tr 60) From "Disapproved" to "No Action."

No Action

S-1007 (Supplemental #1, page Tr 61) From "Action Deferred" to "No Action."

No Action

S-1008 (Supplemental #1, page Tr 61) From "Action Deferred" to "Approved."

Approved

S-1245 (Supplemental #1, page Tr 62) From "Active Support" to "Conditional Approval"

Active Support

A-1435 (Supplemental #2, page Tr 66) From "Action Deferred" to "Disapproved."

Approved

A-1538 (Supplemental #2, page Tr 67) From "Action Deferred" to "No Action."

No Action

... Approved the recommended positions of the Council on the following bills:

S-93—To authorize the State Board of Higher Education to contract with Fairleigh Dickinson University School of Dentistry for acceptance of New Jersey students.
APPROVED

S-100—To amend the Practicing Psychology Licensing Act in several respects concerning the membership on the Board, license fees, and continuing education requirements. *DISAPPROVED*, because no licensing board should be composed purely of licensed practicing professionals.

S-318—To provide for the involuntary commitment of persons believed to be mentally ill. *NO ACTION*

S-324—To require county mental health boards to create the position of mental health administrator. *NO ACTION*

S-327—To permit health insurance coverage, other than group and blanket, for outpatient treatment of the mentally ill. *DISAPPROVED*, because the bill does not clearly indicate the scope of coverage or eligible providers.

S-328—To permit group and blanket health insurance coverage for outpatient treatment for the mentally ill. *DISAPPROVED*, because the bill does not clearly indicate the scope of coverage or eligible providers.

S-329—To permit hospital service corporations to make available coverage for outpatient treatment of the mentally ill. *DISAPPROVED*, because the bill does not clearly indicate the scope of coverage or eligible providers.

S-485—To prohibit the addition of fluorides to any municipal water supply where total fluorides from all sources in the environment exceed an average of 1.2 milligrams per day per person and to require the Department of Environmental Protection to survey all areas of the State for environmental fluorides content. *APPROVED*

S-615—To require all group health insurance policies to provide benefits at least equal in value to 60 days' hospitalization for mental health illness. *DISAPPROVED*, because the wording used would create only the facade of coverage. It is virtually impossible to say that a given psychiatric disorder is subject to "favorable modification by short-term treatment."

S-870—To create and establish a risk register for handicapped and high-risk children in the Department of Health. *DISAPPROVED*, because this bill would be very costly to implement with limited value to the public.

S-902—To authorize the State Board of Pharmacy to give consideration to the geographical needs in granting licenses to applicants and to permit establishment of minimum and maximum prices for prescription drugs. *NO ACTION*

S-973—To establish a permanent Mental Health Oversight Commission. *DISAPPROVED*, because current PSRO, JCAH, and state licensing standards more than adequately insure proper care.

S-1193—To revise the law regulating the practice of dentistry and dental hygiene. *DISAPPROVED*, because this bill would grant the Division of Consumer Affairs unparalleled regulatory discretion over the utilization and training of dental assistants, qualifications for specialized practice in dentistry and licensing requirements. It would (in violation of constitutional rights) mandate that all dentists be required to service medicaid patients and the discretionary exercise of penal power by the Board and Division of Consumer Affairs has been made mandatory. In addition to expansion of powers conferred by particular sections of the act, "the Board is *empowered* to do any and all things

which *may be appropriate* to achieve the objectives contemplated by the New Jersey Dental Practice Act, or which may be *useful* in executing any of the duties, powers or functions of the Board." Such an uncontrolled delegation of authority presents an opportunity for abuse by administrative agencies.

S-1423—To revise penalties for driving while intoxicated; to reduce .15% to .10% alcohol in defendant's blood to presume intoxication; to provide for a program of alcohol education or rehabilitation. *APPROVED*

A-1250—To require all group health insurance policies to provide benefits at least equal in value to 60 days' hospitalization and \$1,000 or 50% of mental health expenses under major medical coverage. *DISAPPROVED*, because without definitive cost data it is unwise to broaden the scope of insurance coverages by legislative mandate.

A-1251—To require all group hospital service contracts to provide benefits at least equal in value to 60 days' hospitalization as a result of mental illness. *DISAPPROVED*, because without definitive cost data it is unwise to broaden the scope of insurance coverages by legislative mandate.

A-1252—To require all group medical service contracts to provide benefits of at least \$1,000 or 50% of mental health expenses under major medical coverage. *DISAPPROVED*, because without definitive cost data it is unwise to broaden the scope of insurance coverages by legislative mandate.

A-1827—To remove the licensing requirement for ophthalmic technicians. *CONDITIONAL APPROVAL*, provided the State Board of Examiners of Ophthalmic Dispensers include an ophthalmologist as one of its members.

Professional Liability . . . Received from Dr. Todd the following report of events concerning professional liability since the September meeting of the Board:

(a) Following adjournment of the September Board meeting, Chubb was informed that MSNJ would proceed with the formation of an insurance company, if feasible and adopted by the House of Delegates;

(b) Chubb agreed not to petition the Commissioner of Insurance to implement the re-insurance facility;

(c) Chubb agreed to meet with the Commissioner of Insurance to assure him that MSNJ's program had validity and that Chubb would work closely with the Society to afford a smooth transition;

(d) Representatives from MSNJ met with the Commissioner at which time he was impressed with the manner in which the Society was undertaking this difficult situation;

(e) A meeting has been scheduled for October 27, at 6:30 p.m. at the Executive Offices, which will include the Board of Trustees, the Ad Hoc Committee on Professional Liability, the Committee on Medical Defense and Insurance, specialty society presidents, component society presidents and executive secretaries/directors, and chiefs of staff of all New Jersey hospitals;

(f) MSNJ's legislative package for malpractice reform is out of Committee and has met with very little, if any, opposition.

House of Delegates Special Session . . . Agreed to reschedule the special session of the House of Delegates for Wednesday, December 1, at 1 p.m. at The Inn of Trenton — luncheon will be provided.

Steering Committee to American Health Systems . . . Approved formation of a steering committee whose responsibility it would be to advise American Health Systems on all necessary decisions to be made prior to the convening of the House of Delegates and to circulate the component societies and hospitals to report on the activities surrounding the investigation of the formation of a captive insurance company. The membership is as follows:

John S. Madara, M.D., President
James S. Todd, M.D., Chairman, Board of Trustees
James E. George, M.D., J.D., Medical Director, MSNJ
Department of Liability Control
Paul J. Kreutz, M.D., Chairman, Committee on Medical
Defense and Insurance
Henry J. Mineur, M.D., Speaker, House of Delegates
Vincent A. Maressa, Executive Director
A member of the New Jersey Association of Osteopathic
Physicians and Surgeons serving ex-officio

Professional Liability

The Medical Society of New Jersey (MSNJ) has had a long-standing and deep involvement in the provision of professional liability coverage for its members. MSNJ has sponsored a group professional liability program since 1961. In addition, the Society has been a national leader in the development and operation of a medical review program. Unlike similar programs in other areas of the country the MSNJ medical review panels have dealt with claims realistically and the program has had a positive impact in reducing losses. As a consequence professional liability costs in New Jersey historically have been no more and often less than in similar demographic areas.

Unfortunately the factors which have adversely affected professional liability costs nationwide

have had a similar impact in New Jersey. The phenomena may be attributed to more liberal court decisions, a changing societal attitude that any injury is compensable whether or not negligence is involved, more sophisticated and consequently riskier surgical and medical procedures, more potent and consequently riskier pharmaceuticals, an increasingly impersonal doctor-patient relationship, and so on. Whatever weight is given to known or suspected causes the effect has been dramatic. Premiums in New Jersey have increased 258 percent since 1973 and 148 percent since 1975.

MSNJ has no argument with the premiums being charged by the current carrier, Federal Insurance Company. MSNJ's consulting actuary is in basic agreement with the rates effective November 1, 1976, and the rates charged in the past several years. However, the sharply increased costs have created an adverse situation for the carrier and its parent corporation, Chubb and Son, Inc. What was a \$7,157,700 case in 1970-1971 policy year has become a 40 plus million dollar risk for policy year 1976-1977. What was an acceptable piece of a balanced book of insurance underwritten in 1971 has come to dwarf other lines and tie up an unacceptable amount of surplus. This is a situation which similarly has affected many casualty insurers.

For these reasons Chubb and Son, Inc. has acted to reduce its risk profile in professional liability by requesting activation of the Reinsurance Authority authorized by the Medical Malpractice Liability Insurance Act (Assembly Bill 1552) N.J.S.A. 17:30D-1 to 16. The activation of the Reinsurance Authority would allow Chubb to cede any amount of the risk to a Reinsurance Association comprised of all personal injury and property damage carriers writing insurance on direct basis in New Jersey. Because Chubb was the largest underwriter of physicians' and surgeons' professional liability in the State, it would administer the Reinsurance Authority. The result is that Chubb would retain the administration of the program while relieving itself of the major portion of the risk. If the experience of the Reinsurance Authority is adverse, excess losses would be assessable against the physicians of New Jersey.

MSNJ is sympathetic to the need of the carrier to reduce the amount of its professional liability exposure. The Society also recognizes the need for the State of New Jersey to have created a vehicle to guarantee that coverage is available if all other markets withdraw. However, MSNJ believes that the establishment of a physician-owned and operated professional liability carrier offers significant advantages over the Reinsurance Authority to both the physicians and all the other citizens of New Jersey.

MSNJ believes separating risk from administration can have only a detrimental influence upon the effectiveness of the insurance plan administration. A firm which administers a plan in which it has little or no risk will tend not to protect the Plans' interests as assiduously as if it were using its own monies. Conversely, the elimination of the third party between physicians and claimants only can cause the physicians to become more intimately aware of practice problems and, because of their direct financial involvement and responsibility, this will cause the profession to enforce higher professional standards. It is the intention of MSNJ to increase the effectiveness of the medical review panels and to coordinate the carriers' activities with the various ongoing peer review programs in the State. In addition a risk-management information program, aimed at orienting members on practice procedures which will reduce the exposure to liability, will be instituted. This can have only a positive effect on the quality of medical care in New Jersey.

A second advantage is the continued availability of coverage through a private market to all physicians and surgeons of New Jersey, whether osteopathic or allopathic. It is recognized that insurance must be offered to all physicians of the State, irrespective of membership in any professional association or organization.

A third advantage is that a physician-owned and operated carrier will be operated at a sharply reduced overhead than that charged by the insurance industry. In addition, investment income, which has never been reflected fully in the professional liability experience, will help ameliorate the costs. As premiums have inflated sharply in the past few years, the insurance in-

dustry has reduced its administrative and production expense factors. However, the physicians' company can operate for considerably less. Their reduced expenses will ultimately be reflected in the costs to the doctor and to the public.

There is ample precedent for provider-owned professional liability carriers. Statewide physician-owned carriers operate in New York, Maryland, New Mexico, Florida, Arizona, Illinois, Michigan, North Carolina, Tennessee, and Alabama. Three regional physician-carriers operate in California. In New Jersey the State Hospital Association has sponsored an Inter-Insurance Exchange for member hospitals and it is now underwriting insurance.

MSNJ does not view the formation of a physician-owned carrier as a fundamental solution to the professional liability crisis, but rather as a more responsive and accountable funding and administrative mechanism. MSNJ is not taking the project lightly and is sensitive to the need to assure that its efforts are highly professional, consistent with New Jersey insurance laws, and a sound venture for the protection of its members. For those reasons MSNJ has obtained consultive services from organizations which have unquestioned competence in the field.

American Health Systems, Inc. of San Francisco is responsible for overall project planning and implementation and coordination of other consultant's services. That firm performed a similar function for the Illinois State Medical Society in the forming of the Medical Inter-Insurance Exchange of Illinois, which now provides professional liability insurance for approximately 8,000 physicians. The firm of Riker, Danzig, Scherer, and Debevoise of Newark has been retained as legal counsel and has done the legal filings, while securities counsel has been obtained from the Chicago firm of Gardner, Carton, and Douglas. Milliman and Robertson is providing actuarial services and Marsh and McLennan is placing reinsurance. In addition, by December 1, 1976, MSNJ will have selected an investment management contractor and an auditor on the basis of proposals received in response to now outstanding requests for proposal.

CMDNJ Notes

Stanley S. Bergen, Jr., M.D.
President, CMDNJ

In the interest of helping physicians and others to update their skills, the CMDNJ Office of Continuing Education (under the direction of Dr. Mark E. Franklin, an assistant vice-president of the College) is expanding in two areas — subject matter and accessibility of learning opportunities. The major approaches are:

- (1) General professional development, consisting, for example, of review courses.
- (2) Intensive preparation for board certification.
- (3) Mini-residencies, an exciting concept still under development that will help practitioners develop a solid foundation in subspecialty areas. The idea for this approach grew out of discussions with the Academy of Medicine of New Jersey.
- (4) A speakers' bureau that will provide expert commentaries and discussions for lay as well as professional audiences.

Dr. Franklin's problem concerns priorities. Resources are limited by the fiscal constraints that affect the entire College. He is going to considerable lengths to find what interests *you* most. This involves analyses of questionnaires and attendees' evaluations, and it means constant discussion with professionals in practice, as well as with professional societies and hospital-based directors of education. Care is taken to schedule sessions that will conflict with other broad-interest activities in the State.

Courses are fully accredited for AMA's Category I. Accreditation by other professional organizations is on an individual basis, as courses are organized. Frequently the organizations serve as co-sponsors, as do appropriate state agencies and community hospitals, when applicable. Some of the professional groups are the Academy of Medicine of New Jersey, the Academy of Family Physicians, the New Jersey Dental Association, the New Jersey State Nurses

Association, and the American Dental Hygiene Association.

Pre-registration is required for most of the continuing education programs for the obvious reason of planning. Registration fees are charged to cover the cost of facilities, course materials and, when applicable, honorariums and meals. Program sites range from our own CMDNJ campuses, to cooperating hospitals, to motels and hotels.

Update programs planned for coming months are on pediatrics, cardiology, anatomy, and the management of chronic oral, facial, and cervical pain. For those interested in broad review of internal medicine, there is an ongoing program at Bayonne Hospital held on two Wednesday afternoons a month, through June.

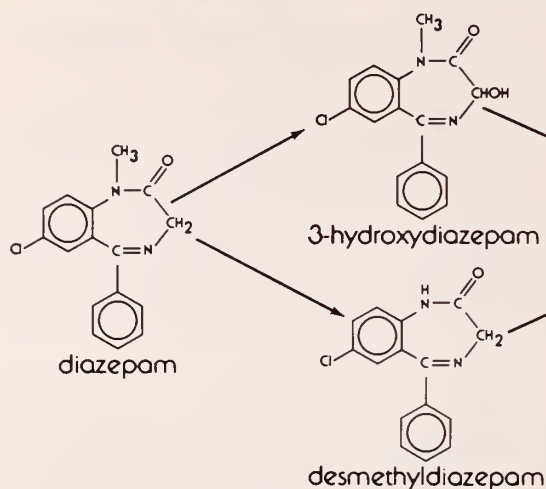
Beginning on February 2nd a 16-week review on anatomy, designed especially for surgeons and residents interested in obtaining board certification, will be offered at CMDNJ's Rutgers campus; each session will last four hours. Long-term programs like this one, and a six-month course in oral surgery also scheduled to start in February at the Dental School, Newark, will serve as a test for future mini-residencies designated to prepare participants for subspecialty certification.

Programs offered in one part of the state will be repeated in another, if there is enough interest and suitable facilities can be found.

The continuing education office has published a brochure listing 85 members of the CMDNJ faculty who are prepared to speak on more than 200 subjects covering most areas of medical, dental, and allied-health interest. For a copy of the pamphlet, or to arrange for a speaker, or for information or suggestions on any continuing education event, you are urged to communicate with Dr. Franklin by phone (201-564-4707) or by writing to: CMDNJ-Office of Continuing Education, P.O. Box 101, University Heights, Piscataway, N.J. 08854.

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may be used in patients with open angle glaucoma who are receiving appropriate therapy.

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Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.



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Lyndon A. Smith, M.D.: Mover for Mental Hospitals*

Dr. Lyndon A. Smith, 44th president of The Medical Society of New Jersey, is remembered today chiefly for his efforts on behalf of the mentally ill. The stimulus of his inaugural address to the Society in 1837 led to legislation which, combined with the aggressive activities of the doughty Dorothea Dix, led to the establishment of the State Hospital at Trenton—one of the first of the modern type mental hospitals established in the United States. Psychiatric historians acknowledge the debt they owe to Lyndon Smith for the transition from callous indifference to humane care in treating the mentally ill.

Lyndon Arnold Smith was born at Haverhill, New Hampshire, on November 11, 1795, son of a clergyman. After preliminary schooling, at age 14, he spent a year in the law office of Daniel Webster, in Portsmouth, before being graduated at Phillips Academy at Exeter, New Hampshire. In 1813 he entered Dartmouth College and received an A.B. degree four years later. After studying medicine in Virginia, Lyndon Smith took his M.D. degree at Dartmouth in 1823. He had the extraordinary distinction of being elected president of the Dartmouth Medical Society while in medical school.

Dr. Smith began practice at Williamstown, Massachusetts. Five years later, the Smiths moved to Newark, New Jersey, and he became a member of The Medical Society of New Jersey.

Dr. Lyndon Smith served as vice president of The Medical Society of New Jersey in 1835 and was elected President in 1837. His presidential address on "Insanity," urged the need for a "State Lunatic Asylum." Responding to this, the Society named a committee to petition the Legislature. That body then appropriated \$500 to survey conditions of the mentally ill in the state. Governor Pennington designated five commissioners to conduct the survey. Meeting at Newark in 1839, the Honorable Lewis Condict, M.D.,

was named chairman and our Dr. Smith became secretary. The Commission visited facilities for care of mental patients in New England, New York, and Pennsylvania before submitting their report to the Legislature.

On March 25, 1845, the New Jersey Legislature voted unanimously to construct a mental hospital at Trenton. This was the beginning of a large family of state hospitals throughout the land. Governor Stratton encouraged this venture and signed the bill which led to the opening of a "model State Lunatic Asylum" at Trenton in 1848. The largest yew tree in New Jersey, near the main entrance to the original building, now recalls the help of Miss Dix, who brought the yew slip from Stoke Poges, England, and planted it on the hospital grounds.

Dr. Smith served as vice president of the American Medical Association in 1859, presiding over all its sessions that year due to illness of the president.

One of Smith's philanthropic interests concerned slavery. He was secretary of the New Jersey African Colonization Society which purchased freedom for many slaves and helped promote the settlement of Liberia through a national organization.

Dr. Smith was also a "manager" of the Newark Presbyterian City Mission and of the American Bible Society. He was a lecturer at the Newark Mechanic's Institute and a Trustee of the Newark Academy. Princeton conferred an honorary degree upon him in 1842.

Dr. Lyndon Smith died at Newark on December 15, 1865. His life and work, in century retrospect, transcended this pilgrim's time and place.

*Abstracted from an historical note, authored by Fred B. Rogers, M.D., which appeared originally in *JMSNJ* (Vol. 63, No. 1, p. 29, January, 1966).

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Therapeutic Drug Information Center*

The Schwartz Inter-National Pharmaceutic and Therapeutic Drug Information Center of the Brooklyn College of Pharmacy, Long Island University, compiles the information contained in this column each month. The Center serves as a source of intelligence on therapeutic and pharmacologic information not readily available to physicians, at no charge to them, and provides this information with minimal time involvement. It is staffed by trained pharmacists; Jack M. Rosenberg, Pharm. D., Associated Professor and Chairman, Division of Clinical Pharmacy, Brooklyn College of Pharmacy, is Director and Walter Modell, M.D., Emeritus Professor of Pharmacology at Cornell University Medical College, is pharmacologist consultant. The service is available Monday through Friday from 9 a.m. to 4:30 p.m. — telephone (212) 622-8989 or 636-7535. The following are questions and answers handled by the Center recently.

1. Do you have any information on the use of zinc sulfate in the treatment of gastric ulcers?

Zinc is known to be an essential trace element for the growth and development of living tissue. Various studies have implicated zinc deficiency in producing hypogonadal dwarfism, idiopathic loss of taste (hypogeusia) and smell (hyposmia), and impairment of wound healing.¹

Zinc sulfate (Zinc-220, Orazinc®) in a dose of 220 mg three times a day has been shown to accelerate the rate of healing of leg ulcers in patients with sickle cell abnormalities in whom the serum zinc concentrations were low.^{2,3} Zinc sulfate also has been used with benefit in treating cutaneous wounds⁴ and idiopathic loss of smell and taste.⁵ However, it is not yet established whether patients with low serum zinc concentrations are the only ones who respond well to this regimen.⁶

Based on the evidence that zinc sulfate helps in wound healing, Fraser, *et al.*⁷ used zinc sulfate as an ancillary in a study involving 24 patients, for evaluating the effect of a new analogue (BX24) of carbenoxolone** on gastric ulcers. It was observed that ulcer size was reduced by 53.5 percent in those (12 patients) who received both BX24 and zinc sulfate, compared with only 21.9 percent in those (12 patients) who received BX24 alone. This difference was not statistically significant but the authors concluded that zinc sulfate might contribute to the healing of gastric ulcer.

Orr⁸ recently reported a case of a 21-year-old patient who underwent two operations for hematemesis and melena without any relief. Gastroscopy 12 days after the second operation revealed a deep lesser curve gastric ulcer and four days later two large melenas occurred. The patient was given zinc sulfate 220 mg three times a day. No further hematemesis or melena occurred and the patient remained "well" for at least three months when last seen.

Frommer⁹ conducted a well controlled, double-blind trial on 18 patients with benign gastric ulcer who had no evidence of zinc deficiency. Ten patients received zinc sulfate in a dose of 220 mg three times a day for three weeks, whereas eight of the remaining received a placebo for an equivalent time. The author found that patients taking zinc sulfate had an ulcer healing rate three times that of patients treated with placebo. No side effects due to zinc sulfate were noted in this study. However, zinc salts when taken internally have been reported to irritate gastric mucosa and cause vomiting.⁶

In conclusion, there is little evidence to determine the role of zinc sulfate in the treatment of gastric ulcers.

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⁵Henkin RI, *et al*: Idiopathic hypogeusia with dysgeusia, hyposmia, and dysosmia: A new syndrome. *JAMA* 217:434-440 (July 26) 1971.

⁶Goodman LS and Gilman A: *The Pharmacological Basis of Therapeutics*, fifth edition. New York, MacMillan, 1975, pp. 1000-1001.

⁷Fraser PM, *et al*: Clinical trial of a new carbenoxolone analogue (BX24), zinc sulfate, and vitamin A in the treatment of gastric ulcer. *Gut* 13:459-463, 1972.

⁸Orr, KB: Healing of gastric ulcers by zinc sulfate (letter to the editor). *Med J Aust* 4:244 (Feb 21) 1976.

⁹Frommer DJ: The healing of gastric ulcers by zinc sulfate. *Med J Aust* 2:793-796, 1975.

2. Could you provide us some information on the use of bromocriptine for the suppression of lactation?

Bromocriptine is a semi-synthetic derivative of ergot alkaloid, devoid of cardiovascular and oxytocic effects of its precursor. It is being investigated in the U. S. by Sandoz for its possible effects in parkinsonism, acromegaly, hypertension, galactorrhea-amenorrhea syndrome and suppression of post-partum lactation. In the United Kingdom, bromocriptine has been approved (in 1976) for the inhibition of prolactin. Bromocriptine is believed to suppress prolactin secretion by a direct action on the pituitary without affecting the release of other pituitary hormones.¹ A number of articles dealing with suppression of lactation by bromocriptine have appeared in the recent past.

*This month's column was prepared by J. M. Rosenberg, Pharm. D., W. A. Simon, Pharm. D., and M. K. Raina, M. Pharm., Ph.D., Brooklyn College of Pharmacy, LIU.

**Carbenoxolone is not commercially available in the U.S. but is widely used in Europe for the treatment of gastric ulcers.

In a double-blind trial, effect of bromocriptine on lactation was compared with diethylstilbestrol (DES) in 38 puerperal women.² Bromocriptine was given 5 mg per day for 14 days and DES 20 mg for seven days followed by a placebo for another seven days (all medications were given orally). It was observed that both compounds had an inhibitory effect on the onset of lactation and breast engorgement. The degree of inhibition was more significantly in favor of bromocriptine, and there were no objective side effects from both drugs at the dosages utilized.

In another study³ 38 women were given bromocriptine 2.5 mg or chlorotrianisene (Tace[®]) 24 mg twice daily orally beginning 12 hours after delivery. Two weeks after therapy, only three out of 23 patients treated with bromocriptine were lactating and without any mammary congestion. Ten out of 15 chlorotrianisene-treated patients continued to lactate and eight had breast engorgement. On the seventh day of treatment, serum prolactin had fallen to 20.6-21.8 ng/ml in the bromocriptine treated group and 48.5-63.2 ng/ml in the other group (normal range for serum prolactin is 0-20 ng/ml). No side effects were reported in either group.

Walker, *et al.*⁴ compared the effect of bromocriptine, placebo and quinnestrol (long-acting estrogen not available in the U.S.) on puerperal lactation and pain associated with mammary congestion. Bromocriptine (2.5 mg twice daily for 14 days) produced a rapid fall in plasma prolactin in 32 women and was reported to be more effective than a 4 mg single dose of quinnestrol in 28 patients, (administered immediately after delivery) or placebo in 27 patients. Pain and mammary congestion were severe in the placebo group, moderate in the quinnestrol group, and mild in the bromocriptine treated group.

In addition to suppression of puerperal lactation, bromocriptine has shown effectiveness in alleviating galactorrhea-amenorrhea syndrome (persistence of lactation and amenorrhea for long periods of time). Spark *et al.*⁵ studied 15 patients before, during and after treatment with bromocriptine, administered in a dose of 2.5 mg three times daily for 24 weeks. These 15 patients had galactorrhea and amenorrhea arising out of different etiologies, six developed the syndrome after pregnancy, five after discontinuation of oral contraceptive therapy and four in association with pituitary tumors refractive to radiotherapy. Treatment with bromocriptine produced significant decrease in serum prolactin levels. Lactation stopped in all the patients in 4-8 weeks of treatment. Menses resumed and cyclical function remained while the patients were on bromocriptine therapy. Galactorrhea and amenorrhea recurred when therapy was discontinued with an increase of prolactin to pre-treatment levels. A further 24-week therapy brought the same results as in the first trial. The authors conclude that bromocriptine therapy is effective for the forms of galactorrhea-amenorrhea syndrome studied.

In conclusion, it appears that the investigational drug bromocriptine is effective in suppressing lactation in puerperal women and as treatment for galactorrhea-amenorrhea syndrome.

References

- ¹Llewellyn-Jones D: Inhibition of lactation. *Drugs* 10:121-129 1975.
- ²Nilsen PA, *et al.*: Study of the suppression of lactation and the influence on blood clotting with bromocriptine (CB 154) (Parlodel): A double-blind comparison with diethylstilbestrol. *Acta Obstet Gynecol Scand* 55:39-44 1976.
- ³Utian WH, *et al.*: Effect of bromocriptine and chlorotrianisene on inhibition of lactation and serum prolactin. A comparative double-blind study. *J Ob Brit Commonwealth* 82: 755-759, 1975.
- ⁴Walker S, *et al.*: Controlled trial of bromocriptine, quinnestrol, and placebo in suppression of puerperal lactation. *Lancet* 2:842-845, 1975.
- ⁵Spark R, *et al.*: Galactorrhea-amenorrhea syndromes: Etiology and treatment. *Ann Intern Med* 84:532-537, 1976.

3. Do you know of any controlled studies concerning the use of dexamethasone in acute stroke?

Stroke, the third leading cause of death in the United States¹ is pathologically based on either cerebral vascular infarction or hemorrhage. Conflicting reports in which corticosteroids were utilized in the treatment of stroke have appeared since the early 1950's.² However, more recently, several controlled studies comparing dexamethasone sodium phosphate (Decadron[®] and Hexadrol[®]) with placebo in the treatment of acute stroke have been reported.

The rationale for using steroids in acute stroke is to lessen the sequelae of cerebral edema, increased intracranial pressure and a disturbed blood brain barrier as well as to counteract the stress factor associated with acute cerebral infarction, hemorrhage or trauma.³ Norris⁴ in a double-blind study treated 53 patients with stroke due to cerebral infarction, of less than 24 hours' duration. Twenty-six patients received 140 mg of dexamethasone administered as 8 mg bolus initially, followed by 4 mg every six hours. The dosage was gradually decreased over a period of 12 days. Twenty-seven patients received matching placebo. Forty-one of the 53 patients survived after 29 days. Five patients died in the placebo group and seven patients died in the steroid group. The author failed to observe any beneficial effect of steroid therapy in acute cerebral infarction.

Bauer and Tellez⁵ in a prospective double-blind study compared the clinical course of 54 patients with acute cerebral infarction. Twenty-eight patients received 120 mg of dexamethasone administered parenterally over a ten-day period. Twenty-six patients received a placebo. Comparisons between the two groups of patients with similar degrees of consciousness showed no appreciable differences.

Tellez and Bauer⁵ treated 19 patients having intracerebral hemorrhage with 120 mg of dexamethasone administered parenterally over a period of ten days. Twenty-one patients received a placebo. Except for a few parameters of the neurological examination which showed improved quality of survival during certain days of the study in the dexamethasone group, no overall statistically significant difference was found between the two groups.

Patten, *et al.*⁶ conducted a double-blind study and treated 31 patients with the diagnosis of acute stroke. Fourteen patients received 10 mg of dexamethasone intravenously followed by 4 mg intramuscularly every six hours for the next ten days. The dosage was then tapered to zero during the ensuing seven days. Seventeen patients were similarly treated with placebo. Analysis of 15 patients most severely affected by their stroke, showed that the patients in the treated group improved 23 percent while the placebo group deteriorated 14 percent. These results were statistically significant. The authors suggested that dexamethasone was a useful adjunct to the therapy of the patient with severe stroke.

In conclusion, it appears that the use of dexamethasone in acute stroke remains at best questionable in value.

References

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³Tellez H and Bauer RB: Dexamethasone as treatment in

cerebrovascular disease: A controlled study in intracerebral hemorrhage. *Stroke* 4:541-546 (July/Aug) 1973.

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⁵Bauer RB and Tellez H: Dexamethasone as treatment in cerebrovascular disease: A controlled study in acute cerebral infarction. *Stroke* 4:547-555 (July/Aug) 1973.

⁶Patten BM, *et al.*: Double-blind study of the effects of dexamethasone on acute stroke. *Neurology* 22:377-383 (Apr) 1972.

PHYSICIANS SEEKING LOCATION IN NEW JERSEY

The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly of them.

CARDIOLOGY — William S. Sarnat, M.D., 711 Keswick Drive, Iowa City, Iowa 52240. Wayne State 1970. Board certified (IM). Group or hospital-based, teaching post. Available August 1977.

Chao-Tarn Cheng, M.D., 5686 Broadview Road, #2508, Parma, Ohio 44134. Kaohsiung (Taiwan) 1969. Board certified (I.M.). Group, partnership, solo, or full-time staff. Available July 1977.

Thomas S. Brodie, M.D., 503 North LaJolla Avenue, Los Angeles, California 90048. Pittsburgh 1972. Group or hospital-based. Available May 1977.

ENDOCRINOLOGY — Daniel L. Lorber, M.D., 119-29th Avenue, South, Nashville, Tennessee 37212. Albert Einstein 1972. Board certified. Group or hospital-based. Available July 1977.

FAMILY PRACTICE — S. Osman, M.D., 10460 Curotte Avenue, Montreal, P.Q., Canada H2C 2Y7. Cairo 1968. Group or full-time emergency. Available.

GASTROENTEROLOGY — Tarig Butt, M.D., 33 Highland Street, Apt. 3-H, New Britain, Connecticut 06052. King Edward, Lahore (Pakistan) 1971. Board certified. Group, partnership, or solo. Available July 1977.

Robert Molle, M.D., 30-60 Crescent Street, Apt. 4-B, Long Island City, New York 11102. Padova (Italy) 1962. Board eligible. Solo. Available January 1977.

HEMATOLOGY/ONCOLOGY — C. U. Zachariah, M.D., 174-10 84th Avenue, Apt. 4G, Jamaica, New York 11432. Madras (India) 1970. Board eligible. Group, solo, or hospital-based. Available July 1977.

Jeffrey S. Perchick, M.D., 84 Redfern Drive, Rochester, New York 14620. SUNY (Buffalo) 1972. Board certified (I.M.). Group or partnership. Available July 1977.

INTERNAL MEDICINE — Sudarshan K. Singal, M.D., 3737 Beaubien Street, Apt. 909, Detroit, Michigan 48201. Amritsar (India) 1969. Subspecialty, gastroenterology. Board certified. Any type practice. Available July 1977.

Mohammed Ashraf Sufi, M.D., 9587 Pickwick Circle East, Taylor, Michigan 48180. Dow, Karachi (Pakistan). Subspecialty, gastroenterology. Group, partnership, academic career. Available July 1977.

Donald Durham Volkmer, M.D., 24 Stoneland Road, Shrewsbury, Massachusetts 01545. Northwestern 1972. Board eligible. Partnership, small group. Available July 1977.

Leonard D. Ehrlich, M.D., 2200 Columbia Pike, Arlington, Virginia 22204. George Washington University. Subspecialty, gastroenterology. Board certified. Group or partnership. Available August 1977.

Geeta Mukhopadhyay Das, M.D., 140 North Broadway, Apt. L-4, Irvington, New York 10533. Royal College (England) 1972. Board eligible. Part-time group or hospital-based. Available.

Ashoke Kumar Das, M.D., 140 North Broadway, Apt. L-4, Irvington, New York 10533. Royal College (England) 1971. Board eligible. Group, partnership, solo, hospital-based salaried position. Available.

Martin S. Lerman, M.D., 7601 Holmes Run Drive, Falls Church, Virginia 22040. Georgetown. Board eligible. Group, partnership, or solo. Available July 1977.

Mark A. Sullivan, M.D., 2834 Midvale Avenue, Philadelphia, Pennsylvania 19129. Cornell 1972. Subspecialty, gastroenterology. Board certified. Group or partnership. Available July 1977.

James L. Stammer, M.D., 5314 La Cieniga Circle, San Antonio, Texas 78233. CMDNJ 1970. Subspecialty, gastroenterology. Board eligible. Group, partnership. Available August 1977.

Chia Yian Chou, M.D., 86-31 57th Avenue, Elmhurst, New York 11373. Taipei (Taiwan) 1970. Board eligible. Solo or group. Available July 1977.

Bernard Davidoff, M.D., 344 West 72nd Street, Apt. 3-R, New York 10023. Columbia 1973. Board certified. Group, associate, solo. Available March 1977.

Rasiklal Amin, M.D., 56 Benedict Avenue, Staten Island, New York 10314. Gujarat (India). Board certified. Group, partnership, solo. Available.

James H. Wolf, M.D., 235 Townhouse, Briarcrest Gardens, Hershey, Pennsylvania 17033. NYU 1974. Board eligible. Group or partnership. Available July 1977.

Daniel M. Weinstock, M.D., 60 Plaza Street, Brooklyn, New York 11238. Johns Hopkins 1974. Board eligible. Group or partnership. Available July 1977.

Robert P. Hoffman, M.D., Naval Hospital, Beaufort, South Carolina 29902. Albany 1970. Subspecialty infectious diseases. Board certified. Group, partnership, hospital. Available July 1977.

OBSTETRICS AND GYNECOLOGY — Chaw P. Sun, M.D., 71 Ford Place, Bridgeport, Connecticut 06610. Taiwan 1970. Board eligible. Solo or partnership. Available July 1977.

Meena Aggarwal, M.D., 621 Stuyvesant, 401 Cooper Landing Road, Cherry Hill 08002. King George, Lucknow (India) 1968. Board eligible. Group, partnership, hospital. Available July 1977.

David C. Handwerker, M.D., 9133 Winton Road, Apt. 25, Cincinnati, Ohio 45231. NYU 1973. Board eligible. Group, partnership, solo. Available July 1977.

OCCUPATIONAL MEDICINE — Alexander A. Boytar, M.D., 3101 Skyline Dr., Wilmington De. 19808. Budapest, 1947. Board certified — (IM). Industrial medicine, pharmaceutical or chemical company, group of industrial physicians. Available.

OPHTHALMOLOGY — George R. Zambelli, M.D., 1353 Bradshire Road, Columbus, Ohio. St. Louis University. Board eligible. Solo, partnership, group. Available July 1977.

Edward B. Feinberg, M.D., 2819 Renfrew Avenue, Ann Arbor, Michigan 48105. Mt. Sinai 1971. Board eligible. Group, association, or partnership. Available July 1977.

Howard B. Goldman, M.D., 160 Cabrini Boulevard, New York, New York 10033. NYU (Bellevue) 1973. Solo, associate, or group. Available July 1977.

ORTHOPEDICS — A. M. Arain, M.D., 21 Narraticon, Deptford 08096. King Edward, Lahore (Pakistan) 1962. Board eligible. Solo. Available April 1977.

PATHOLOGY — Charles K. Allam, M.D., 236 Fuller Terrace, Orange 07050. French Faculty of Medicine,

Beirut (Lebanon) 1961. Board certified. Group or partnership (hospital-based). Available.

PEDIATRICS — Stephen Schlesinger, M.D., 2309 Tarleton Drive, Charlottesville, Virginia 22901. SUNY (Buffalo) 1970. Board certified. Any type practice. Available July 1977.

Robert Sasson, M.D., 142 Longmeadow Apartments, Cornwells Heights, Pennsylvania 19020. SUNY (Downstate). Board eligible. Group, partnership, or solo. Available July 1977.

Francis DiBona, M.D., 265 Parklake, Ann Arbor, Michigan 48103. Wisconsin 1969. Subspecialty, nephrology. Board certified. Large group (hemodialysis). Available September 1977.

Raymond Kahn, M.D., 4635 Clanranald, Montreal, Canada H3X 2R8. McGill 1973. Board eligible. Group partnership, or solo. Available July 1977.

Nawal Siage, M.D., 30-60 Crescent Street, Apt. 4-B, Long Island City, New York 11102. Damascus (Syria) 1971. Board eligible. Group or solo. Available January 1977.

Richard L. Dvorin, M.D., 73 Keene Street, Providence, Rhode Island 02906. Meharry 1974. Board eligible. Group, partnership, or HMO. Available July 1977.

Daniel Cohen, M.D., 2606 Piedmont Road, Apt. C-12, Atlanta, Georgia 30324. SUNY (Downstate) 1974. Group or partnership. Available July 1977.

PHYSICAL MEDICINE AND REHABILITATION — Marius Focseneanu, M.D., 66-36 Yellowstone Boulevard, Apt. 15-G, Forest Hills, New York 11375. Bucharest 1959. Board eligible. Institutional group.

PSYCHIATRY — Melvin W. Cohen, M.D., 681 Clarkson Avenue, Brooklyn, New York 11203. Meharry 1968. Board eligible. Clinic, hospital-based, or group. Available January 1977.

Herbert Schein, M.D., 20 Hospital Drive, Toms River 08753. Leiden (Holland) 1968. Board eligible. Clinic, group, partnership, association, or solo. Available.

PULMONARY MEDICINE — Donald L. Epstein, M.D., 9 Winding Brook Drive, Apt. 2F, Guilderland, New York 12084. CMDNJ 1972. Board eligible. Group, partnership, solo. Available July 1977.

Lawrence S. Slotnick, M.D., 2157 Hawaii Avenue, Forrestal Village, Great Lakes, Illinois 60088. SUNY (Downstate) 1970. Group or hospital. Available July 1977.

RADIOLOGY — Benjamin Anthony Giella, Jr., M.D., Box 1316 Hopkinson House, Washington Square South, Philadelphia, Pennsylvania 19106. University of Pennsylvania 1970. Special interest — diagnostic radiology. Board eligible. Hospital, group, or partnership. Available July 1977.

Nanjappa C. Sadasivan, M.D., 16520 Schaefer Street, Apt. #7, Detroit, Michigan 48235. Stanley (India) 1969. Special interest — ultrasound and diagnostic radiology. Board eligible. Any type practice. Available July 1977.

Phyllis R. Jarvis, M.D., 5116 Professional Drive, Apt. 88, Wichita Falls, Texas 76302. NYU 1970. Special interest — diagnostic and pediatric radiology. Board certified. Group, partnership, academic. Available July 1977.

SURGERY — Peter A. Jarvis, M.D., 5116 Professional Drive, Wichita Falls, Texas 76302. Cornell 1970. Board certified. Group, partnership. Available July 1977.

Kenneth R. Pozner, M.D., 265-24 74th Avenue, Floral Park, New York 11004. NYU 1970. Partnership or group. Available July 1977.

Kenneth N. Holwitt, M.D., 3350 Tisdale Drive, Lexington, Kentucky 40504. West Virginia 1968. Subspecialty, cardio-thoracic surgery. Board eligible. Group. Available July 1977.

Darayes S. Mobed, M.D., 80 Guion Place, Apt. 11-N, New Rochelle, New York 10801. Dow, Karachi

(Pakistan) 1971. Subspecialty, peripheral vascular surgery. Board eligible. Partnership, group. Available July 1977.

UROLOGY — Steven Ross, M.D., 4469 Chestnut Ridge Road, Tonawanda, New York 14150. CMDNJ 1972. Board eligible. Group, partnership, or solo practice. Available July 1977.

Charles Bamberger, M.D., 2775 Bender Avenue, Akron, Ohio 44319. University of Chile 1969. Partnership or solo practice. Available July 1977.

Stuart Zykorie, M.D., 152 Baltic Street, Brooklyn, New York 11201. NYU (Downstate) 1972. Board eligible. Partnership or group. Available July 1977.

Stephen C. Rochman, M.D., 529 Martin Avenue, Morgantown, West Virginia 26505. Meharry 1970. Board eligible. Partnership or group. Available July 1977.

William Augustus Newell: Physician, Governor, Congressman.*

William Augustus Newell came from a family known for its medical men. Among his forebears, Dr. James Newell of Freehold had been the sixth president of The Medical Society of New Jersey in 1772, and his son, Dr. Elisha Newell of Allentown, became its twentieth president in 1795. William was born at Franklin, Ohio, on September 5, 1817, his parents having temporarily moved there from Freehold. He was graduated from Rutgers in 1836 and received his M.D. degree from the University of Pennsylvania three years later.

Dr. Newell's long career ranged from seaside and rural New Jersey to The White House and the Pacific Northwest. He began practice with an uncle, Dr. G. Augustus Hankinson, at Manahawkin, on Barnegat Bay in Ocean County. There in 1840, he witnessed the burial of thirteen victims from the wreck of an Austrian brig, the *Count Perasto*. These 13 people had drowned within sight of shore for want of rescue facilities. This tragedy prompted an idea for a life-saving plan and service — which the doctor subsequently led to enactment.

Newell moved to Imlaystown in Monmouth County. There, in 1843, he accomplished a remarkable plastic surgical procedure — the

formation of a new eyelid which was created from the cheek of the patient. The operation was so successful as to leave scarcely a vestige of the deformity.

Joining The Medical Society of New Jersey in 1839, Dr. Newell served as a delegate to the state body and was, for a term, president of the Monmouth County Component Medical Society. In 1844 he settled in Allentown and between periods of elected office practiced there. He was elected to the U.S. House of Representatives in 1847 and served four terms. While in Congress he treated former president John Quincy Adams during his last illness. From 1857 to 1860, Dr. Newell was Governor of New Jersey. A close personal friend of Abraham Lincoln, he was appointed physician to The White House in 1864. President Hayes designated him Governor of the Washington Territory in 1880, a post he held for four years, followed by six years of service as Commissioner of Indian Affairs. Returning to New Jersey in 1899, Dr. Newell resumed practice in Allentown, where he died on August 8, 1901 and was buried in the Presbyterian Churchyard in that town.

*Abstracted from an historical note, authored by Fred B. Rogers, M.D., which appeared originally in *JMSNJ* (Vol. 63, No. 4, p. 146, April 1966).

CLINICAL NOTES

IUD — Vintage 1924 — Presenting as Partial Large Bowel Obstruction

Henry J. Schwarz, M.D., North Bergen

Purpose of this report is to record a case with unusual circumstances resulting from the insertion of an intrauterine device (IUD) in 1925. This procedure was not as rare at that time as we might believe.

Case Report

An 86-year-old female patient was admitted to North Hudson Hospital (Weehawen, New Jersey) in October, 1975. Her problems were back and abdominal pain and constipation. She was disoriented due to an organic mental syndrome. The patient was taking Tylenol® for back pain and digoxin 0.25 mg for atrial fibrillation for the last three years.

Examination revealed the blood pressure to be 130/80 and the pulse 100, with atrial fibrillation. The chest was clear, but the heart was enlarged. There was a grade II/IV systolic murmur heard all over the precardium. The abdomen was distended, tympanitic, and felt doughy; the liver and spleen were palpable. Bowel sounds were present but abdominal tenderness was not evident. Breasts were normal; there was no cervical adenopathy and no edema of the limbs. Pelvic examination revealed a nodular uterus with thickening in the adnexa.

Laboratory Data: WBC 99,900; polys 84, lymphs 14, mono 2; hgb. 14; sed rate 52; VDRL negative; pap smear negative for malignant cells; urine culture revealed no growth but vaginal discharge culture grew E-coli and non-hemolytic strep which were sensitive to all antibiotics. Serum sodium, potassium, CO₂, FBS, BUN, and urinalyses were normal. EKG showed atrial fibrillation; chest x-ray showed signs of arteriosclerotic heart disease. A flat x-ray film of the abdomen revealed a wire-type device resembling a tuning fork in the uterus. X-ray of the lumbar spine showed osteoporosis; intravenous pyelogram and cholecystogram were normal. Barium enema revealed diverticulosis and a gastrointestinal series showed hiatal hernia. Cystogram was negative and sigmoidoscopy was normal.

Further questioning of the patient's daughter uncovered added pertinent information. There was no known previous hospitalization of the patient, but the daughter recalled hearing of an office procedure which was performed on her mother in 1925 and which was prompted by the patient's desire to limit her family.

Course of Treatment: The patient was continued on digoxin. Keflex® was administered for treatment of pyometria with leukemoid reaction. The white blood count fell to 28,400. Subsequently the patient underwent a supracervical hysterectomy with bilateral salpingo-oophorectomy and appendectomy. Pathological report showed pyometritis due

to the IUD, endometritis with focal myometritis and adenomyosis, and the previously mentioned wire intrauterine device. The patient had a smooth recovery and was discharged on the seventh postoperative day.

Comment

The wire was identified in a 1945 edition of *Practical Birth Control Methods* by Norman Hines, Ph.D. It is called a wishbone and displays the shape illustrated. (Figure)



INTRAUTERINE
DEVICE

In the 1920's American doctors sometimes fitted fashionable women desiring to control their fertility with studs, stems, wishbones, or other similar intrauterine devices. It often was claimed that these devices were made of solid gold in order to enhance the price, but many were made of cheap, non-corrosive metals or chrome-plated metals.

Dickinson and Bryant summed up the subject wisely when they said, "The number sold has been enormous, the forms various, the accidents serious, the protection uncertain."

It is extraordinary that it took 50 years for this patient to develop pyometria.

References

Dickinson R L, Bryant L S: *Control of Conception: An Illustrated Medical Manual*. Baltimore, Williams and Wilkins, 1931.

Hines N: *Practical Birth Control Methods*. New York, Viking, 1943.

LETTERS TO THE JOURNAL

Re: Fournier's Disease

October 4, 1976

Dear Sir:

I agree wholeheartedly with the findings of the authors of this article in the September issue of *The Journal* (73: 778) that the syndrome of Fournier's disease consists of explosive gangrene of the scrotum with rapid toxemia.

However, it may be misleading reading the history of the patient in that he was a "known alcoholic" and that he had been drinking heavily for a few days before being admitted. He was ill-nourished, dehydrated, and had poor general health.

A few years ago I saw a patient in consultation in Ancora State Hospital with similar symptomatology. However, the patient was well-nourished, hydrated, and had no alcoholic history since he had been a patient for a long time. In spite of multiple incisions the condition became progressively worse until almost the entire scrotal skin had disappeared. Following antibiotic therapy the temperature became nor-

mal. The wound was packed daily with iodoform gauze. Skin grafts were considered; however, epithelialization was complete with the iodoform gauze so that the grafting was not necessary.

Fortunately, this condition is extremely rare and certainly the improved general hygiene of men must be considered an important factor. However, in spite of good hygiene the condition crops up occasionally.

(signed) Stanley J. Okulicz, M.D.

Munchausen Syndrome

October 6, 1976

Dear Sirs:

I am currently engaged in research on the Munchausen (Hospital Addiction) Syndrome and its variants. I would like to correspond with any other physicians who have had personal contact with such patients. To this end I would appreciate it if you would print this letter in your Correspondence (or Letters) section. All responses to be addressed to: S. E. Hyler, M. D., 5620 Netherland Avenue, Riverdale, New York, 10471.

(Signed) S. E. Hyler, M. D.

ANNOUNCEMENTS

Course in Pediatric Clinical and Theoretical Allergy

In cooperation with the New Jersey Medical School, CMDNJ, the Children's Hospital of Newark is sponsoring a review course in clinical problems in pediatric allergy designed for pediatricians, family physicians, and allergists. The program runs from September through May. Lectures are held each Thursday from 11 a.m. to 12 noon in the Chapel Conference Room at United Hospitals of Newark. In addition a

pediatric allergy clinic will be held from 8:30 to 10 a.m. on each of these days, and from 12 noon to 1 p.m. there will be a pediatric conference. Hour-for-hour credit will be awarded in Category I of the AMA Physician's Recognition Award. Tuition is \$100. For information, please address a communication to Arthur F. Fost, M.D., Director of Allergy, Children's Hospital of Newark, 15 South 9th Street, Newark 07107.

The schedule for December and January is as follows:

Dec. 9 — Asthma
 Dec. 14 — Inhalation Therapy
 Dec. 23 — Pulmonary Conferences
 Dec. 30 — Hospital Management of Asthma
 Jan. 6 — Office Management of Allergic Child
 Jan. 13 — Chronic Chest Diseases in Children
 Jan. 20 — Complications and Prognosis of Asthma
 Jan. 27 — Pediatric Pulmonary Conference

Graduate Course in Urology

On January 26, 1977, at the Brookdale Hospital Medical Center in Brooklyn, the New York University Post-Graduate Medical School will offer a course entitled "Controversies in Urology." This is a clinically oriented program, and presentations are geared to provide the practicing urologist with the latest information in patient care, emphasizing the various approaches that may be used for each particular condition. Tuition is \$50 and credit will be awarded in AMA Category I. For information, please communicate with Dr. William Mackler, Brookdale Hospital Medical Center, Linden Boulevard, Brooklyn, New York 11211 — 212-240-5311.

Multidisciplinary Management of Chronic Head, Neck, and Jaw Dysfunction

On March 4 and 5, 1977, at Holiday Inn — Jetport, Elizabeth, a course in multidisciplinary management of chronic head, neck, and jaw dysfunction will be offered by the office of continuing education of CMDNJ. The programs which run from 9 a.m. to 5:15 p.m. each day will consist of lectures, slides, and live demonstrations. The fee is \$150 and includes luncheons. Thirteen credit hours will be awarded in AMA Category I; application for accreditation has been made also to the Academy of Family Physicians. For additional information and application for registration, please communicate with the Office of Continuing Education, CMDNJ, Rutgers Medical School, P.O. Box 101, University Heights, Piscataway 08854 — (201) 564-4707.

AAP Seminar

From March 10 to 13, 1977, the New Jersey Chapter of the American Academy of Pediatrics will hold its spring meeting at Paradise Island Hotel in Nassau. Topics to be presented include immunizations and central nervous system infec-

tions, pediatric and adolescent gynecology, pediatric ophthalmology, and sports medicine. Application has been made for 12 credit hours in Category I of the AMA Physician's Recognition Award. All pediatricians are cordially invited to attend and additional information may be obtained from Mr. Robert W. Matlack, Executive Assistant, New Jersey Chapter, at 59 East Main Street, Moorestown 08057, telephone (609) 234-0330.

Graduate Medical Assembly in New Orleans

From March 28 through 31, 1977, the New Orleans Graduate Medical Assembly, which was founded in 1936 and is dedicated to the advancement of medical and scientific education, will hold its 40th annual colloquium at the Fairmount Hotel in New Orleans. Presentations will be made by those distinguished in their fields, and there will be a clinicopathologic conference, a trauma symposium, and scientific exhibits. Entertainment will be provided for one's spouse. Registration is \$125; for students, residents, and interns there is no fee. Application has been made for accreditation by the American Academy of Family Physicians and the American College of Emergency Physicians. For information, please communicate with Miss Lois Neary, Executive Director, New Orleans Graduate Medical Assembly, 1430 Tulane Avenue, New Orleans, Louisiana 70112.

Graduate Course in Radiology of Bones and Joints

The Duke University Medical Center's Department of Radiology will present a postgraduate course on radiology of bones and joints from March 28 to April 1, 1977 at Durham, North Carolina. Emphasis will be on tutorial type teaching of basic subjects on bones and joints using original roentgenograms supplemented with slide material. There will be ample opportunity for discussion. A detailed abstract book with references will be provided. The AMA will award 30 credit hours in Category I for attendance. For further information, please communicate with Robert McLelland, M.D., Director, Radiology Postgraduate Education, Duke University Medical Center, Box 3808, Durham, North Carolina 27710.

MEETINGS OF MEDICAL INTEREST

This listing is compiled through the cooperation of the Committee on Medical Education of The Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the College of Medicine and Dentistry of New Jersey. For information on accreditation, please contact the sponsoring organization(s).

Dec.

- | | |
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| <p>14 Usefulness of Methadone in Addiction
9-10:30 a.m. — Monmouth Medical Center
(Sponsored by Monmouth Medical Center and AAFP)</p> <p>14 Hematuria and Its Causes
8 a.m. — S. Ocean Co. Hospital, Manahawkin
(Burlington County Memorial Hospital and AAFP)</p> <p>14 Burns
8 p.m. — Paul Kimball Hospital, Lakewood
(Sponsored by AMNJ and AAFP)</p> <p>14 Thyroid Diseases
9 p.m. — Bayonne Hospital
(Sponsored by AMNJ and AAFP)</p> <p>14 Vaginal Surgery
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)</p> <p>14 Optics for the Clinical Ophthalmologist
4:30-6:30 p.m. — 15 So. 9th St., Newark
(Sponsored by Associated Eye Residencies of New Jersey AMNJ)</p> <p>15 Neurotransmitters
1-2:30 p.m. — New Jersey Medical School, Newark
(Sponsored by CMDNJ and AMNJ)</p> <p>15 Special Applications of Radiation Therapy
10:30-11:30 a.m., Clara Maass Hospital, Belleville
(Sponsored by Clara Maass Hospital and AAFP)</p> <p>15 Infectious Disease in Community Hospital
1 p.m. — Christ Hospital
(Sponsored by Christ Hospital)</p> <p>15 Neurology in a Psychiatric Setting
1-2:30 p.m. — Marlboro Psychiatric Hospital
(Sponsored by Marlboro Psychiatric Hospital and AMNJ)</p> <p>15 Infectious Disease in a Community Hospital
1-3 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital)</p> <p>15 Complications of Alcoholism
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)</p> <p>15 Hypersensitivity and Immunity
11:30 a.m.-12:30 p.m. — V.A. Hospital, East Orange
(Sponsored by East Orange V.A. Hospital)</p> <p>15 Special Rounds, General Surgery and Specialties
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)</p> | <p>15 Hemotherapy 1976
1-2 p.m. — VA Hospital, Lyons
(Sponsored by VA Hospital, Lyons, and AMNJ)</p> <p>15 Psychiatric Aspect of Endocrine Disorders
1 p.m. — Trenton Psychiatric Hospital
(Sponsored by AMNJ and AAFP)</p> <p>15 Prolapse of the Mitral Valve
9:30-11 a.m. — Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital)</p> <p>15 Facial Trauma and Reconstructive Surgery
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)</p> <p>16 Inhalation Therapy and O₂ and Mist Therapy
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)</p> <p>16 Aldosterone in Edema
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)</p> <p>16 Common Ear, Nose and Throat Problems
9:30-10:45 p.m. — Woodbury Country Club, Cooper St., Woodbury
(Sponsored by Gloucester County Medical Society and AMNJ)</p> <p>16 Regional Chest Conference, Northern New Jersey
7:30-9:30 p.m. — Overlook Hospital, Summit
(Sponsored by New Jersey Thoracic Society and AMNJ)</p> <p>16 Topics in Neurosurgery
4-5 p.m. — VA Hospital, East Orange
(Sponsored by CMDNJ, VA Hospital, East Orange, and AMNJ)</p> <p>16 Institutionalization — The Effect on the Patient
11 a.m.-12 noon, Greystone Park Psychiatric Hospital
(Sponsored by Greystone Park Psychiatric Hospital and AMNJ)</p> <p>16 Physiology of Menstruation
20 Cervical and Uterine Diseases
23 Ovarian and Adnexal Inflammatory Disease
5-6 p.m. — St. Francis Medical Center, Trenton
(Sponsored by St. Francis Medical Center)</p> <p>16 Psychiatry Mortalities
23 Death by Terror
12 noon — Carrier Clinic, Belle Mead
(Sponsored by Carrier Clinic)</p> |
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- 17 **Glomerulonephritis**
9-10 a.m. — St. Francis Medical Center, Trenton
(Sponsored by Hahnemann Medical College and AAFP)
 - 17 **Bleeding Diseases**
12 noon — Freehold Area Hospital
(Sponsored by AMNJ and AAFP)
 - 17 **Nephrotic Syndrome in Children**
10 a.m. — Monmouth Medical Center
(Sponsored by Monmouth Medical Center and AAFP)
 - 18 **Water and Electrolyte Balance in Surgery**
8:45 a.m.-1 p.m. — Newark Beth Israel Medical Center
(Sponsored by Newark Beth Israel Medical Center and AMNJ)
 - 19 **Clinical Application of Arterial Blood Gases**
10-11 a.m. — Bayonne Hospital
Bronchoactive Drugs
11-11:30 a.m. — Bayonne Hospital
Diagnostic Techniques of the Lung
11:30-12 noon — Bayonne Hospital
(Sponsored by CMDNJ, Rutgers, and Bayonne Hospital)
 - 21 **Infectious Diseases**
12 noon — St. Mary's Hospital, Orange
(Sponsored by AMNJ and AAFP)
 - 21 **Chronic Renal Failure**
12 noon — Hospital Center at Orange
(Sponsored by AMNJ and AAFP)
 - 21 **Contact B-Scan Ultra-Sonography**
8-10 p.m. — Englewood Men's Club
(Sponsored by Englewood Surgical Society and AMNJ)
 - 22 **Management of Trauma Patient**
10:30 a.m.-12 noon — Passaic General Hospital
(Sponsored by Hahnemann Medical College and AAFP)
 - 22 **Gastrointestinal Bleeding**
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
 - 22 **Computerized Tomography**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
 - 22 **When to Refer to the Geneticist**
9:30-11 a.m. — Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital)
 - 22 **Headaches in Children**
8 a.m. — Southern Ocean County Hospital, Manahawkin
(Sponsored by Burlington County Memorial Hospital and AAFP)
 - 22 **Philosophical Background of Transactional Analysis, Part II**
3-4:30 p.m. — Fair Oaks Hospital, Summit
(Sponsored by Fair Oaks Hospital)
 - 22 **The Aging Heart**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
 - 22 **Special Rounds, Internal Medicine**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 23 **Pediatric Pulmonary Conference**
11-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
 - 29 **Clinical Pathology Conference**
9:30-11 — Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital)
 - 30 **Hospital Management of Childhood Asthma**
11 a.m.-12 noon — United Hospitals of Newark
(Children's Hospital of Newark and CMDNJ)
- 1977
Jan.
- 3 **Diagnosis and Treatment of Shock**
1 p.m. — Ancora Psychiatric Hospital, Hammonton
(Sponsored by AMNJ and AAFP)
 - 3 **Pacemakers**
8 p.m. — Community Memorial Hospital, Toms River
(Sponsored by AMNJ and AAFP)
 - 3 **Resistance to Change in an Obsessional Patient**
8-10 p.m. — 39 Crescent Ave., Passaic
(Sponsored by AMNJ and Essex Psychiatric Seminar)
 - 3 **Blood Component Therapy**
 - 6 **Cerebral Lesions**
 - 10 **Spinal Cord Lesions**
 - 13 **Peripheral Nerve Lesions**
 - 17 **Spinal Hip Fractures**
 - 20 **Bone Tumor**
 - 27 **Sequential Management of Cancer**
 - 31 **Abdominal Trauma**
5-6 p.m. — St. Francis Medical Center, Trenton
(Sponsored by St. Francis Medical Center)
 - 4 **Shock Therapy**
5-6 p.m. — CMDNJ-Rutgers Medical School, Piscataway
(Sponsored by AMNJ and CMDNJ-Rutgers Medical School)
 - 4 **Coronary Artery Disease**
11 a.m. — Greystone Park Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
 - 5 **Cancer Research**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
 - 5 **Special Rounds, Pathology**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 5 **Clinical Endocrinology**
3 p.m. — Fair Oaks Hospital, Summit
(Sponsored by AMNJ and AAFP)

- 5 **Fiberoptic Bronchoscopy**
9:30-11 a.m. — Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital)
- 5 **Myasthenia Gravis**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
- 5 **Selected Topics in Gastroenterology**
8-10 p.m. — Medical Center, Princeton
(Sponsored by N.J. Gastroenterology Society)
- 5 **Seizures in Children and Adolescents**
- 19 **Approach to Thyroid Nodule**
10:30-12 noon — Passaic General Hospital
(Sponsored by Hahnemann Medical College and AAFP)
- 5 **Emergency Medicine**
- 12 **Use of Local Anesthesia in the High-Risk Surgical Patient**
- 26 **Arthritis**
1-3 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital and AMNJ)
- 5 **Alcoholism In-patient Centers**
1-2 p.m. — VA Hospital, Lyons
(Sponsored by AMNJ and VA Hospital, Lyons)
- 5 **Glomerulonephritis**
9:15-10:15 a.m. — St. Barnabas Medical Center, Livingston
(Sponsored by St. Barnabas Medical Center and AMNJ)
- 5 **Child Abuse and Neglect**
9:30 a.m.-3:30 p.m. — Glassboro State College
(Sponsored by AMNJ and CMDNJ-Rutgers Medical School)
- 6 **Topics in Neurosurgery**
- 13 4-5 p.m. — VA Hospital, East Orange
(Sponsored by CMDNJ, VA Hospital, East Orange and AMNJ)
- 27
- 6 **Tranquilizers in the Age of Anxiety**
8:30-10 p.m. — Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital, Bergen County Medical Society and AMNJ)
- 6 **The Allergic Child**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
- 6 **Respiratory Failure and Mechanical Ventilation**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 7 **Indications for Cardiac Surgery in Rheumatic and Congenital Heart Disease**
8:30 a.m. — United Hospitals of Newark
(Sponsored by AMNJ and AAFP)
- 7 **Xerox and Xerotomography**
12 noon-1 p.m. — St. Mary's Hospital, Orange
(Sponsored by AMNJ and St. Mary's Hospital)
- 9 **Renal Function Tests**
10 a.m.-10:30 a.m. — Bayonne Hospital
Acute Renal Failure
10:30-11 a.m. — Bayonne Hospital
Chronic Renal Failure
11-11:30 a.m. — Bayonne Hospital
Renin
11:30 a.m.-12 noon — Bayonne Hospital
(Sponsored by Bayonne Hospital and CMDNJ)
- 10 **Management of Carcinoma of Urinary Bladder**
12 noon-1 p.m. — Overlook Hospital, Summit
(Sponsored by Overlook Hospital and AMNJ)
- 10 **Couple and Family Therapy**
17 8:30-10:30 p.m. — 314 Broadwell Ave., Union
24 (Sponsored by AMNJ and N. J. Center for Family
31 Studies)
- 11 **Office Cardiology**
12:00 noon — Monmouth Medical Center
(Sponsored by Monmouth Medical Center and AAFP)
- 11 **Pre-Hospital Coronary Care**
8 p.m. — Paul Kimball Hospital, Lakewood
(Sponsored by AMNJ and AAFP)
- 11 **Sports Medicine**
9 p.m. — Bayonne Hospital
(Sponsored by AMNJ and AAFP)
- 11 **Abnormal Pap Smear in Young Woman**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 12 **Weakness and Fatigue**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 12 **Special Rounds, Pediatrics**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 12 **Clinical Immunology**
11:30 a.m. — Rahway Hospital
(Sponsored by AMNJ and AAFP)
- 12 **Surgery in Ulcerative Colitis**
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
- 12 **Endocrine Diseases of the Male and Female Gonads**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
- 12 **Lithium Therapy**
1:30-2:30 p.m. — Trenton Psychiatric Hospital
(Sponsored by AMNJ and Trenton Psychiatric Hospital)
- 12 **Anorexia Nervosa — A Psychomatic Paradigm**
9:00-10:30 a.m. — Monmouth Medical Center
(Sponsored by Monmouth Medical Center and AAFP)
- 13 **Chronic Chest Disease in Children**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMNJ)

- 13 **Workshop on Hypertension**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 13 **Pacemaker Therapy and Chronic Myocardial Disease**
- 27 **Depression**
10:30 a.m. — Monmouth Medical Center
(Sponsored by Monmouth Medical Center and AAFP)
- 13 **Management of Breech Presentation**
11 a.m. — Monmouth Medical Center
(Sponsored by Monmouth Medical Center and AAFP)
- 15 **Clinical Case Presentation**
9 a.m.-12 noon — St. Barnabas Hospital, Livingston
(Sponsored by AMNJ, Orton Society, St. Barnabas Hospital and Essex County Psychological Association)
- 18 **Endotoxic Shock**
12 noon — St. Mary's Hospital, Orange
(Sponsored by AMNJ and AAFP)
- 18 **Regional Chest Conference, Northern New Jersey**
7:30-9:30 p.m. — St. Joseph's Hospital and Medical Center, Paterson
(Sponsored by New Jersey Thoracic Society and AMNJ)
- 19 **Clinical Psychiatry Series**
1 p.m.-2:30 p.m. — New Jersey Medical School, Newark
(Sponsored by CMDNJ and AMNJ)
- 19 **Alcoholism**
1 p.m.-2:30 p.m. — Marlboro Psychiatric Hospital
(Sponsored by Marlboro Psychiatric Hospital and AMNJ)
- 19 **Hepatitis**
1 p.m. — Trenton Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
- 19 **Acid Base Disturbances**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
- 19 **Out-Patient Management of COPD**
11:30 a.m.-12:30 p.m. — V.A. Hospital, East Orange
(Sponsored by East Orange V.A. Hospital)
- 19 **Pathophysiology of Anemia**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 19 **Special Rounds, General Surgery and Specialties**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 19 **The Violent Patient**
3-4:30 p.m. — Fair Oaks Hospital, Summit
(Sponsored by AMNJ & Fair Oaks Hospital)
- 20 **Asthma**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
- 20 **Immunologic and Pathophysiological Aspects of Asthma**
5-6:30 p.m. — Somerset Hospital, Somerville
(Sponsored by Allergy Society)
- 20 **Sex Therapy — The Impotent Male**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 21 **Clinical Immunology**
12 noon — Freehold Area Hospital
(Sponsored by AMNJ and AAFP)
- 21 **Bleeding Diseases**
4:30 p.m. — Holiday Inn, Deepwater
(Sponsored by Salem County Medical Society, AMNJ and AAFP)
- 21 **Electrocardiography and Arrhythmia**
- 23 **Playboy Resort and Country Club, Great Gorge**
(Sponsored by International Medical Corporation and AAFP)
- 21 **Socialization in Infancy**
10 a.m. — Monmouth Medical Center
(Sponsored by Monmouth Medical Center and AAFP)
- 22 **Hepatic Resection**
10 a.m. — Monmouth Medical Center
(Sponsored by Monmouth Medical Center and AAFP)
- 23 **Clinical Approach of Acid-Base Disturbances**
10-11 a.m. — Bayonne Hospital
Case Reviews of Acid-Base Disorders
11 a.m.-12 noon — Bayonne Hospital
(Sponsored by Bayonne Hospital and CMDNJ)
- 25 **Child Abuse and Neglect**
8 p.m. — Warren Hospital, Phillipsburg
(Sponsored by AMNJ and AAFP)
- 26 **Hepatitis**
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
- 26 **Malignant Melanomas**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
- 26 **Gram Negative Infections in Surgery**
9-11 a.m. — Auditorium, Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 26 **Special Rounds, Internal Medicine**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 27 **Pediatric Pulmonary Conference**
11-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
- 27 **Sex Therapy — Non-Orgasmic Female**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 29 **Family Systems Theory and Therapy**
10 a.m.-12 noon — Seton Hall University, South Orange
(Sponsored by AMNJ and New Jersey Center for Family Studies)

Feb.

- 1 **Pre-Hospital Coronary Care**
11 a.m. — Greystone Park Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
- 1 **Burn Management**
5-6 p.m. — CMDNJ-Rutgers Medical School, Piscataway
(Sponsored by AMNJ and CMDNJ-Rutgers Medical School)
- 2 **Schizophrenia**
3-4:30 p.m. — Fair Oaks Hospital, Summit
(Sponsored by AMNJ & Fair Oaks Hospital)
- 2 **Vascular Gut**
1-5 p.m. — St. Barnabas Medical Center, Livingston
(Sponsored by AMNJ, New Jersey Gastroenterological Society, and St. Barnabas Medical Center)
- 2 **Renal Energy Metabolism**
9:15-10:15 a.m. — St. Barnabas Medical Center, Livingston
(Sponsored by AMNJ and St. Barnabas Medical Center)
- 2 **Laboratory Interpretations**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 2 **Special Rounds, Pathology**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 2 **Gastrointestinal Bleeding**
1 p.m. — Christ Hospital, Jersey City
(Sponsored by AMNJ and AAFP)
- 2 **Gout and Pseudogout**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
- 2 **The Tasks of Psychiatry**
- 16 **Biology and Gender Role**
1-2:30 p.m. — New Jersey Medical School, Newark
(Sponsored by CMDNJ and AMNJ)
- 2 **Ulcerative Colitis and Ileitis**
- 16 **Treatment of Common Dermatoses**
10:30-12 noon — Passaic General Hospital
(Sponsored by Hahnemann Medical College and AAFP)
- 3 **Topics in Neurosurgery**
- 10 **4-5 p.m. — VA Hospital, East Orange**
(Sponsored by CMDNJ, VA Hospital, East Orange, and AMNJ)
- 24
- 3 **Hypersensitivity Pneumonitis**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
- 3 **Low Renin Hypertension**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 4 **Complications of Heart Failure**
12 noon-1 p.m. — St. Mary's Hospital, Orange

(Sponsored by AMNJ and St. Mary's Hospital)

- 4 **Laboratory Interpretations**
8:30 a.m. — United Hospitals of Newark
(Sponsored by AMNJ and AAFP)
- 4 **Dilemmas in Informed Consent**
8:30-10 p.m. — Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital, Bergen County Medical Society and AMNJ)
- 5 **Family Systems Theory and Therapy**
- 12 **10 a.m.-12 noon — Seton Hall University, S. Orange**
(Sponsored by AMNJ and New Jersey Center for
- 19 **Family Studies)**
- 26
- 7 **Couple and Family Therapy**
8:30-10:30 p.m. — 314 Broadwell Ave., Union
(Sponsored by AMNJ and New Jersey Center for Family Studies)
- 7 **Married Couple with Severe Sexual Difficulties**
8-10 p.m. — 11 Ridgewood Ave., Glen Ridge
(Sponsored by Essex Psychiatric Seminar and AMNJ)
- 7 **Coronary Artery Disease**
1 p.m. — Ancora Psychiatric Hospital, Hammonton
(Sponsored by AMNJ and AAFP)
- 7 **Vascular Surgery**
8 p.m. — Community Memorial Hospital, Toms River
(Sponsored by AMNJ and AAFP)
- 8 **Cerebral Vascular Disease**
8 p.m. — Paul Kimball Hospital, Lakewood
(Sponsored by AMNJ and AAFP)
- 8 **Acute Renal Failure**
9 p.m. — Bayonne Hospital
(Sponsored by AMNJ and AAFP)
- 8 **Ovarian Tumors**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 9 **Genetic Counseling**
1-3 p.m. — Christ Hospital, Jersey City
(Sponsored by Christ Hospital and AMNJ)
- 9 **Management of Hepatitis**
11:30 a.m. — Rahway Hospital
(Sponsored by AMNJ and AAFP)
- 9 **Current Chemotherapy**
1:30 p.m. — Runnells Hospital, Berkeley Heights
(Sponsored by AMNJ and AAFP)
- 9 **Fluid and Electrolyte Imbalance**
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
- 9 **Hyperaldosteronism**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
- 9 **Common Intestinal Parasites**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)

- 9 **Special Rounds, Obstetrics — Gynecology**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 9 **Psychiatry — Studies in the Subjective Sense of Time**
1-2:30 p.m. — Marlboro Psychiatric Hospital
(Sponsored by Marlboro Psychiatric Hospital and AMNJ)
- 10 **Aeroallergens, Air Pollutants and Respiratory Disease**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
- 10 **Exercise and Cardiac Rehabilitation**
- 24 **Occupational Lung Disease**
10:30 a.m. — Monmouth Medical Center
(Sponsored by Monmouth Medical Center and AAFP)
- 10 **Diseases of the Vulva**
11 a.m. — Monmouth Medical Center
(Sponsored by Monmouth Medical Center and AAFP)
- 10 **Renal Transplantation**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 11 **Pancreatitis**
9-10 a.m. — St. Francis Hospital, Trenton
(Sponsored by Hahnemann Medical College and AAFP)
- 14 **Family Structure and Therapy**
9-10:30 a.m. — Monmouth Medical Center
(Sponsored by Monmouth Medical Center and AAFP)
- 15 **Gallstones**
8:30-9:30 p.m. — Irvington General Hospital
(Sponsored by AMNJ and Irvington General Hospital)
- 15 **Thyroid Disease**
12 noon — St. Mary's Hospital, Orange
(Sponsored by AMNJ and AAFP)
- 15 **Anesthetic Air Pollution in the Operatory**
8:30 p.m. (preceded by dinner at 6 p.m.) — Fireside Inn, Rochelle Park
(Sponsored by Dental Section, AMNJ)
- 16 **Nutrition**
1 p.m. — Christ Hospital, Jersey City
(Sponsored by AMNJ and AAFP)
- 16 **Thanatology**
3 p.m. — Fair Oaks Hospital, Summit
(Sponsored by AMNJ and AAFP)
- 16 **The Violent Patient**
1 p.m. — Trenton Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
- 16 **Congestive Heart Failure**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
- 16 **Clinical Physiology of the Control of Breathing**
11:30 a.m.-12:30 p.m. — V.A. Hospital, East Orange
(Sponsored by East Orange V.A. Hospital)
- 16 **Psychosomatic Problems in Children**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 16 **Special Rounds, General Surgery and Specialties**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 17 **Molds and Pollens**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
- 17 **Contact Dermatitis**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 17 **Cardiovascular Aspects of Jogging**
5-6:30 p.m. — Somerset Hospital, Somerville
(Sponsored by Somerset Hospital)
- 18 **Sports Medicine**
4:30 p.m. — Holiday Inn, Deepwater
(Sponsored by Salem County Medical Society, AMNJ and AAFP)
- 18 **Blood Gases**
12 noon — Freehold Area Hospital
(Sponsored by AMNJ and AAFP)
- 18 **Immuno-Therapy for Lung Cancer**
8-10:30 p.m. — Glen Ridge Country Club
(Sponsored by AMNJ and New Jersey Society of Thoracic Surgeons)
- 19 **Endocrinology and Metabolism**
- 26 **Frenchman's Reef Hotel, St. Thomas, Virgin Islands**
(Sponsored by AMNJ and CMDNJ-New Jersey Medical School)
- 18 **Cardio-Pulmonary Emergencies in Children**
10 a.m. — Monmouth Medical Center
(Sponsored by Monmouth Medical Center and AAFP)
- 19 **Sepsis in Surgery**
10-11 a.m. — Monmouth Medical Center
(Sponsored by Monmouth Medical Center and AAFP)
- 22 **Current Treatment of Burns**
8 p.m. — Warren Hospital, Phillipsburg
(Sponsored by AMNJ and AAFP)
- 22 **Special Rounds, Surgery**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 23 **Breast Cancer**
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
- 23 **Adolescent Medicine**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
- 23 **Common Pediatric Orthopedic Problems**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)

- 24 Pediatric Pulmonary Conference**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
- 24 Preservation of Ischemic Myocardium**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 28 Carcinoma of the Cervix**
12 noon-1 p.m. — Overlook Hospital, Summit
(Sponsored by Overlook Hospital and AMNJ)
- 29 Special Rounds, Medicine**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- Mar.**
- 1 Fluid and Electrolyte Imbalance**
11 a.m. — Greystone Park Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
- 2 Infertility**
1 p.m. — Christ Hospital, Jersey City
(Sponsored by AMNJ and AAFP)
- 2 Fluid and Electrolyte Imbalance**
11:30 a.m. — Rahway Hospital
(Sponsored by AMNJ and AAFP)
- 2 Coagulopathies and Dysproteinemia: Multiple Myeloma and Waldenstroms**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
- 2 Child Health**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 2 Special Rounds, Pathology**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 2 Selected Topics in Gastroenterology**
8-10 p.m. — Valley Hospital, Ridgewood
(Sponsored by N. J. Gastroenterology Society)
- 2 Chronic Obstructive Pulmonary Disease**
- 16 Acute Renal Failure**
- 30 Bedside Diagnosis of Heart Disease**
10:30-12 noon — Passaic General Hospital
(Sponsored by Hahnemann Medical College and AAFP)
- 2 Drug Induced Psychosis**
- 16 Recent Developments in Mental Health Law**
1-2:30 p.m. — New Jersey Medical School, Newark
(Sponsored by CMDNJ and AMNJ)
- 2 Infections in Chronic Renal Failure**
9:15-10:15 a.m. — St. Barnabas Medical Center, Livingston
(Sponsored by AMNJ and St. Barnabas Medical Center)
- 2 Subjective Sense of Time**
3-4:30 p.m. — Fair Oaks Hospital, Summit
(Sponsored by AMNJ & Fair Oaks Hospital)
- 2 Specialized Techniques in Family Therapy**
9 7:30-9:30 p.m. — Seton Hall University, South Orange
16 (Sponsored by AMNJ and New Jersey Center for
23 Family Studies)
30
- 3 Topics in Neurosurgery**
10 4-5 p.m. — VA Hospital, East Orange
17 (Sponsored by CMDNJ, VA Hospital and AMNJ)
24
31
- 3 Diagnosis of Rhinitis**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
- 3 Bypass Grafts**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 4 Renal Transplantation**
8:30 a.m. — United Hospitals of Newark
(Sponsored by AMNJ and AAFP)
- 4 Community Psychiatry**
1:30-2:30 p.m. — Trenton Psychiatric Hospital
- 11 Neuroanatomy and Neuropathology**
2:45-3:45 p.m. — Trenton Psychiatric Hospital
- 18 Clinical Neurology**
4-5 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital)
- 4 Hospital Ethics Committee — Pro and Con**
8:30-10 p.m. — Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital, Bergen County Medical Society and AMNJ)
- 4 Head, Neck, and Jaw Dysfunction**
- 5** 9 a.m.-5:15 p.m. — Holiday Inn-Jetport, Elizabeth
(Sponsored by CMDNJ Office of Continuing Education, Piscataway)
- 7 Couples Group Therapy**
14 7:00-9:00 p.m. — Various locations
21 (Sponsored by AMNJ and New Jersey Center for
28 Family Studies)
- 7 Immunology**
8 p.m. — Community Memorial Hospital, Toms River
(Sponsored by AMNJ and AAFP)
- 8 Positive Aspects of Aging**
9-10:30 a.m. — Monmouth Medical Center
(Sponsored by Monmouth Medical Center and AAFP)
- 8 Cortical Steroid Therapy**
8 p.m. — Paul Kimball Hospital, Lakewood
(Sponsored by AMNJ and AAFP)
- 8 Clinical Endocrinology**
9 p.m. — Bayonne Hospital
(Sponsored by AMNJ and AAFP)
- 8 Nutrition & Family Medicine**
12 noon — Monmouth Medical Center
(Sponsored by Monmouth Medical Center and AAFP)

- 9 **Joint Conference**
Coachman Inn, Cranford
(Sponsored by the New Jersey Thoracic Society and New Jersey Chapter American College of Chest Physicians)
- 9 **Obstructive Lung Disease**
1:30 p.m. — Runnells Hospital, Berkeley Heights
(Sponsored by AMNJ and AAFP)
- 9 **Current Chemotherapy, Breast Cancer**
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
- 9 **Management of Patients in Diabetic Coma**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
- 9 **Disorders of Biliary Tract and Pancreas**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 9 **Special Rounds, Pediatrics**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 10 **Combined Endocrinology Seminar**
- 24 **Thyroid Function**
10:30 a.m. — Monmouth Medical Center
(Sponsored by Monmouth Medical Center and AAFP)
- 10 **Perennial Allergic Rhinitis, Vasomotor Rhinitis and Serous Otitis Media**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
- 10 **Use and Abuse of Dialysis**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 11- **AAP Spring Meeting**
- 13 **Paradise Island Hotel, Nassau, Bahamas**
- 12 **The Family Therapist's Own Family**
- 13 **9 a.m.-4 p.m. — Holiday Inn, East Orange**
(Sponsored by AMNJ and New Jersey Center for Family Studies)
- 15 **Breast Cancer**
5:30-6:30 p.m. — St. Mary's Hospital, Orange
(Sponsored by AMNJ and St. Mary's Hospital)
- 15 **Hematology-Diagnosis of Anemia**
12 noon — St. Mary's Hospital, Orange
(Sponsored by AMNJ and AAFP)
- 16 **Bronchial Asthma**
11:30 a.m.-12:30 p.m. — V.A. Hospital, East Orange
(Sponsored by East Orange V.A. Hospital)
- 16 **Physical Medicine in Office Practice**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 16 **Special Rounds, General Surgery and Specialties**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 16 **Thyroid Diseases**
1 p.m. — Trenton Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
- 16 **Current Advances in Cancer Management**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
- 16 **Forensic Psychiatry**
1-2:30 p.m. — Marlboro Psychiatric Hospital
(Sponsored by Marlboro Psychiatric Hospital and AMNJ)
- 16 **Concepts of Success Phobia**
3-4:30 p.m. — Fair Oaks Hospital, Summit
(Sponsored by AMNJ and Fair Oaks Hospital)
- 17 **Drug Therapy of Upper Respiratory Allergy**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
- 17 **Family Counseling**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 17 **Management of Angina**
5-6:30 p.m. — Somerset Hospital, Somerville
(Sponsored by Somerset Hospital)
- 18 **Sodium and Potassium Metabolism**
9:10 a.m. — St. Francis Medical Center, Trenton
(Sponsored by Hahnemann Medical College and AMNJ)
- 18 **Headache**
12 noon — Freehold Area Hospital
(Sponsored by AMNJ and AAFP)
- 18 **Pediatric Endocrinology**
10 a.m. — Monmouth Medical Center
(Sponsored by Monmouth Medical Center and AAFP)
- 19 **Vascular Surgery**
10-11 a.m. — Monmouth Medical Center
(Sponsored by Monmouth Medical Center and AAFP)
- 22 **Echo-Cardiography**
8 p.m. — Warren Hospital, Phillipsburg
(Sponsored by AMNJ and AAFP)
- 22 **Pacemakers**
12 noon — Hospital Center at Orange
(Sponsored by AMNJ and AAFP)
- 23 **Current Radiation Therapy, Breast Cancer**
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
- 23 **Arthritis**
11:30 a.m. — Rahway Hospital
(Sponsored by AMNJ and AAFP)
- 23 **Neurological Diagnosis**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)

- 23 Special Rounds, Internal Medicine**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 23 Virology and Interferon**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital and AAFP)
- 23 Cancer and the Nervous System**
1 p.m. — VA Hospital, East Orange
(Sponsored by AMNJ, CMDNJ-New Jersey Medical School and VA Hospital)
- 23 Ischemic Heart Disease**
9:30 a.m.-4 p.m. — Marriott Hotel, Saddle Brook
(Sponsored by AMNJ and American Heart Association, Bergen County Chapter)
- 24 Pediatric Pulmonary Conference**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
- 24 Marriage Counseling**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 25 Community Psychiatry**
1:30-2:30 p.m. — Trenton Psychiatric Hospital
Psychology
2:45-3:45 p.m. — Trenton Psychiatric Hospital
Forensic Psychiatry
4-5 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital)
- 26 Athletic Injuries**
9 a.m. — Valley Hospital, Ridgewood
(Sponsored by Valley Hospital)
- 30 Hepatitis**
3 p.m. — Fair Oaks Hospital, Summit
(Sponsored by AMNJ and AAFP)
- 30 Aortic Valvular Disease**
9-11 a.m. — Riverview Hospital, Red Bank
(Sponsored by Riverview Hospital, and AAFP)
- 30 Respiratory Virus Infections**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 30 Clinical Hematology**
9:30 a.m.-4:30 p.m. — St. Michael's Medical Center, Newark
(Sponsored by AMNJ and St. Michael's Medical Center)
- 31 Diagnosis and Treatment of Headache**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- Apr.**
- 1 Community Psychiatry**
1:30-2:30 p.m. — Trenton Psychiatric Hospital
Psychology
2:45-3:45 p.m. — Trenton Psychiatric Hospital
Forensic Psychiatry
4-5 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital)
- 1 The Hospitalized Child**
- 15 Childhood Rheumatoid Disease**
10 a.m. — Monmouth Medical Center
(Sponsored by Monmouth Medical Center and AAFP)
- 1 Hypertension**
12 noon-1 p.m. — St. Mary's Hospital, Orange
(Sponsored by AMNJ and St. Mary's Hospital)
- 1 Proper Use of Antibiotics**
8:30 a.m. — United Hospitals of Newark
(Sponsored by AMNJ and AAFP)
- 4 Depression in Adolescent Girl**
8-10 p.m. — 60 Melrose Place, Montclair
(Sponsored by Essex Psychiatric Seminar and AMNJ)
- 4 Orthopedic Problems**
8 p.m. — Community Memorial Hospital, Toms River
(Sponsored by AMNJ and AAFP)
- 4 The Practice of Couples Group Therapy**
- 11 7-9 p.m. — Various locations**
(Sponsored by AMNJ & N. J. Center for Family Studies)
- 5 Headache**
11 a.m. — Greystone Park Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
- 6 Parkinson's Disease and Related Disorders**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 6 Special Rounds, Pathology**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 6 Selected Topics in Gastroenterology**
8-10 p.m. — St. Michael's Medical Center, Newark
(Sponsored by N. J. Gastroenterology Society)
- 6 Chronic Schizophrenia**
1-2:30 p.m. — N.J. Medical School, Newark
(Sponsored by CMDNJ and AMNJ)
- 6 Obstructive Uropathy**
9:15-10:15 a.m. — St. Barnabas Medical Center, Livingston
(Sponsored by AMNJ and St. Barnabas Medical Center)
- 6 Specialized Techniques in Family Therapy**
7:30-9:30 p.m. — Seton Hall University
(Sponsored by AMNJ and New Jersey Center for Family Studies)
- 7 Neurosurgical Conferences**
- 14 4-5 p.m. — VA Hospital, East Orange**
- 21 (Sponsored by CMDNJ, VA Hospital, East Orange, and AMNJ)**
- 28**
- 7 Hyperlipidemia**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 9 Fluids and Electrolyte Balance**
10-11 a.m. — Monmouth Medical Center
(Sponsored by Monmouth Medical Center & AAFP)

- 10 **Intrauterine Growth Retardation**
11 a.m. — Monmouth Medical Center
(Sponsored by Monmouth Medical Center & AAFP)
- 12 **New Developments in Psychiatry and Law**
9-10:30 a.m. — Monmouth Medical Center
(Sponsored by Monmouth Medical Center & AAFP)
- 12 **Review and Update of OB/GYN**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 12 **Collagen Disease**
8 p.m. — Paul Kimball Hospital, Lakewood
(Sponsored by AMNJ and AAFP)
- 12 **Echo-Cardiography**
9 p.m. — Bayonne Hospital
(Sponsored by AMNJ and AAFP)
- 13 **Proper Use of Blood Gases**
1 p.m. — Christ Hospital, Jersey City
(Sponsored by AMNJ and AAFP)
- 13 **Current Surgical Techniques, Breast Cancer**
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
- 13 **Headache**
11:30 a.m. — Rahway Hospital
(Sponsored by AMNJ and AAFP)
- 13 **Cardiac Complications of Antidepressant Drugs and Major Tranquilizers**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 13 **Special Rounds, Pediatrics**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 13 **Therapy of Ambulatory Patients Who Have Had Psychosis**
1-2:30 p.m. — Marlboro Psychiatric Hospital
(Sponsored by Marlboro Psychiatric Hospital and AMNJ)
- 13 **Update on Collagen Disease**
10:30-12 noon — Passaic General Hospital
(Sponsored by Hahnemann Medical College and AAFP)
- 14 **Review Symposium — Malpractice**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 14 **Drug Allergy**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
- 14 **Inflammatory Bowel Disease**
- 28 **Multiple Sclerosis**
10:30 a.m. — Monmouth Medical Center
(Sponsored by Monmouth Medical Center and AAFP)
- 15 **Community Psychiatry**
- 22 **1:30-2:30 p.m. — Trenton Psychiatric Hospital**
- Mental Deficiency**
2:45-3:45 p.m. — Trenton Psychiatric Hospital
- Forensic Psychiatry**
4-5 p.m. — Trenton Psychiatric Hospital
(Sponsored by Trenton Psychiatric Hospital)
- 15 **Scanning**
12 noon — Freehold Area Hospital
(Sponsored by AMNJ and AAFP)
- 17 **Seminar in Medical Humanism**
8:30-10 p.m. — Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital, Bergen County Medical Society and AMNJ)
- 19 **Cardiac Arrhythmias**
12 noon — St. Mary's Hospital, Orange
(Sponsored by AMNJ and AAFP)
- 20 **Child Abuse and Neglect**
1 p.m. — Trenton Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
- 20 **Pulmonary Pathology in Connective Tissue Disease**
11:30 a.m.-12:30 p.m. — V.A. Hospital, East Orange
(Sponsored by V.A. Hospital, East Orange)
- 20 **New Cardiac Drugs**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 20 **Special Rounds, General Surgery and Specialties**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 20 **New Frontiers in Psychiatry**
1-2:30 p.m. — N.J. Medical School, Newark
(Sponsored by CMDNJ and AMNJ)
- 21 **Insect Allergy**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
- 21 **Carcinoma of Lung**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 21 **Diagnostic Approaches to the Ischemic Lower Extremity**
5-6:30 p.m. — Somerset Hospital, Somerville
(Sponsored by Somerset Hospital)
- 26 **Endotoxic Shock**
12 noon — Hospital Center at Orange
(Sponsored by AMNJ and AAFP)
- 26 **Gastrointestinal Bleeding**
8 p.m. — Warren Hospital, Phillipsburg
(Sponsored by AMNJ and AAFP)
- 27 **Emotional Crises in Practice**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 27 **Special Rounds, Internal Medicine**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)

- 27 Neonatal Infections**
10:30 a.m.-12 noon — Passaic General Hospital
(Sponsored by Hahnemann Medical College and AAFP)
- 27 Lung Cancer**
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
- 28 Pediatric Pulmonary Conference and Case Presentations**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
- 28 Use and Abuse of Diuretics**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- May**
- 2 Emergency Medicine**
8 p.m. — Community Memorial Hospital, Toms River
(Sponsored by AMNJ and AAFP)
- 2 A Learning-Disabled Adolescent**
8-10 p.m. — 1046 South Orange Avenue, Short Hills
(Sponsored by Essex Psychiatric Seminar and AMNJ)
- 3 Cerebral-Vascular Disease**
11 a.m. — Greystone Park Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
- 4 Thanatology**
1 p.m. — Christ Hospital, Jersey City
(Sponsored by AMNJ and AAFP)
- 4 Sports Medicine**
11:30 a.m. — Rahway Hospital
(Sponsored by AMNJ and AAFP)
- 4 Low Back Pain**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 4 Glomerulonephritis**
9:15-10:15 a.m. — St. Barnabas Medical Center, Livingston
(Sponsored by AMNJ and St. Barnabas Medical Center)
- 4 Special Rounds, Pathology**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 4 Psychiatric Rehabilitation**
1-2:30 p.m. — N.J. Medical School, Newark
(Sponsored by CMDNJ and AMNJ)
- 5 Neurosurgical Conferences**
- 12 4-5 p.m. — VA Hospital, East Orange**
(Sponsored by CMDNJ, VA Hospital, East Orange, and AMNJ)
- 19**
- 26**
- 5 Veterinary Allergy**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
- 5 Fluid and Electrolyte Balance**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- 5 Seminar in Medical Humanism**
8:30-10 p.m. — Bergen Pines County Hospital, Paramus
(Sponsored by Bergen Pines County Hospital, Bergen County Medical Society, and AMNJ)
- 6 Proper Use of Blood Gases**
8:30 a.m. — United Hospitals of Newark
(Sponsored by AMNJ and AAFP)
- 6 White Cells Disorders**
10 a.m. — Monmouth Medical Center
(Sponsored by Monmouth Medical Center and AAFP)
- 10 Leukemia**
8 p.m. — Paul Kimball Hospital, Lakewood
(Sponsored by AMNJ and AAFP)
- 10 Plastic Surgery**
9 p.m. — Bayonne Hospital
(Sponsored by AMNJ and AAFP)
- 10 What's New in Allergy?**
12 noon — Monmouth Medical Center
(Sponsored by Monmouth Medical Center and AAFP)
- 11 Academy of Medicine Annual Awards Dinner**
6 p.m. — Chanticleer, Millburn
- 11 Thanatology**
1:30 p.m. — Runnells Hospital, Berkeley Heights
(Sponsored by AMNJ and AAFP)
- 11 Obstructive Lung Disease**
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
- 11 Sputum Examination**
11:30 a.m.-12:30 p.m. — V.A. Hospital, East Orange
(Sponsored by East Orange V.A. Hospital)
- 11 Patient with Advanced Cancer**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
- 11 Special Rounds, Pediatrics**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
- 11 Role of the Therapist in Psychotherapy**
- 18 1-2:30 p.m. — Marlboro Psychiatric Hospital**
(Sponsored by Marlboro Psychiatric Hospital and AMNJ)
- 11 Clinical Shock**
10:30-12 noon — Passaic General Hospital
(Sponsored by Hahnemann Medical College and AAFP)
- 12 Marital Counseling and Gender Identity**
11 a.m. — Monmouth Medical Center
(Sponsored by Monmouth Medical Center and AAFP)
- 12 Management of Diabetes**
- 26 Hyperalimentation**
10:30 a.m. — Monmouth Medical Center
(Sponsored by Monmouth Medical Center and AAFP)
- 12 Urticaria and Angioedema**
11 a.m.-12 noon — United Hospitals of Newark,
(Sponsored by Children's Hospital of Newark and CMDNJ)

- 12 **Immunology and Asthma**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
 - 14- **MSNJ Annual Meeting**
 - 17 Haddon Hall, Atlantic City
 - 16 **Diagnosis and Management of Non-Hodgkins Lymphoma**
12 noon-1 p.m. — Overlook Hospital, Summit
(Sponsored by Overlook Hospital and AMNJ)
 - 17 **Tuberculosis**
12 noon — St. Mary's Hospital, Orange
(Sponsored by AMNJ and AAFP)
 - 18 **What's New in Office Gynecology?**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
 - 18 **Special Rounds, General Surgery and Specialties**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 18 **Pharmacology of Sleep**
1-2:30 p.m. — N.J. Medical School, Newark
(Sponsored by CMDNJ and AMNJ)
 - 19 **Atopic Dermatitis**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
 - 19 **Outpatient Management of Pulmonary Tuberculosis**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
 - 19 **Cellular Engineering in Medicine**
5-6:30 p.m. — Somerset Hospital, Somerville
(Sponsored by Somerset Hospital)
 - 20 **Diabetes**
12 noon — Freehold Area Hospital
(Sponsored by AMNJ and AAFP)
 - 20 **Duodenal-Pancreatico Catheterization**
9-10 a.m. — St. Francis Hospital, Trenton
(Sponsored by Hahnemann Medical College and AAFP)
 - 24 **Thanatology**
12 noon — Hospital Center at Orange
(Sponsored by AMNJ and AAFP)
 - 24 **Bleeding Diseases**
8 p.m. — Warren Hospital, Phillipsburg
(Sponsored by AMNJ and AAFP)
 - 25 **Proper Use of Blood Gases**
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
 - 25 **Headache**
9-11 a.m. — Middlesex General Hospital
(Sponsored by Middlesex General Hospital and AAFP)
 - 25 **Special Rounds, Internal Medicine**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 25 **Pneumonia: Viral and Bacterial**
10:30-12 noon — Passaic General Hospital
(Sponsored by Hahnemann Medical College and AAFP)
 - 26 **Pediatric Pulmonary Conference and Case Presentations**
11 a.m.-12 noon — United Hospitals of Newark
(Sponsored by Children's Hospital of Newark and CMDNJ)
 - 26 **Preventative Measures in Heart Disease**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
- June
- 1 **Tuberculosis — Outpatient Treatment**
1 p.m. — Christ Hospital, Jersey City
(Sponsored by AMNJ and AAFP)
 - 1 **Special Rounds, Pathology**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 2 **Neurosurgical Conferences**
 - 9 4-5 p.m. — VA Hospital, East Orange
(Sponsored by CMDNJ, VA Hospital, East Orange, and AMNJ)
 - 16
23
30
 - 2 **Pulmonary Function Tests**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)
 - 3 **Psychiatry-Medical Surgical Emergencies**
8:30 a.m. — United Hospitals of Newark
(Sponsored by AMNJ and AAFP)
 - 6 **Non-Specific Urethritis**
8 p.m. — Community Memorial Hospital, Toms River
(Sponsored by AMNJ and AAFP)
 - 7 **Arthritis**
11 a.m. — Greystone Park Psychiatric Hospital
(Sponsored by AMNJ and AAFP)
 - 8 **Special Rounds, Pediatrics**
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)
 - 8 **Endotoxic Shock**
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)
 - 8 **Management of Arrhythmias**
10:30-12 noon — Passaic General Hospital
(Sponsored by Hahnemann Medical College and AAFP)
 - 8 **Annual Meeting New Jersey Thoracic Society**
CMDNJ-Rutgers Medical School, Piscataway
(Sponsored by New Jersey Thoracic Society)
 - 9 **Proper Use of Blood Gas**
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)

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| <p>14 Endocrine Changes in Menopause
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)</p> <p>14 Pacemakers
8 p.m. — Paul Kimball Hospital, Lakewood
(Sponsored by AMNJ and AAFP)</p> <p>14 Allergy
9 p.m. — Bayonne Hospital
(Sponsored by AMNJ and AAFP)</p> <p>15 Adult Respiratory Distress Syndrome
11:30 a.m.-12:30 p.m. — V.A. Hospital, East Orange
(Sponsored by East Orange V.A. Hospital)</p> <p>15 Special Rounds, General Surgery and Specialties
10:30 a.m.-12 noon — St. Mary's Hospital, Passaic
(Sponsored by St. Mary's Hospital)</p> <p>15 Transcultural Psychiatry
1-2:30 p.m. — New Jersey Medical School, Newark
(Sponsored by CMDNJ and AMNJ)</p> <p>16 Duodenal Ulcer Disease
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)</p> <p>16 Current Concepts of Addiction
5-6:30 p.m. — Somerset Hospital, Somerville
(Sponsored by Somerset Hospital)</p> | <p>17 Thyroid Diseases
12 noon — Freehold Area Hospital
(Sponsored by AMNJ and AAFP)</p> <p>20 Status Asthmaticus
10 a.m. — Monmouth Medical Center
(Sponsored by Monmouth Medical Center and AAFP)</p> <p>21 Hypertension
12 noon — St. Mary's Hospital, Orange
(Sponsored by AMNJ and AAFP)</p> <p>22 Arterial Blood Gases
10:30-12 noon — Passaic General Hospital
(Sponsored by Hahnemann Medical College and AAFP)</p> <p>22 Hemorrhagic Shock
1:30-3 p.m. — St. Mary's Hospital, Passaic
(Sponsored by AMNJ and AAFP)</p> <p>22 Special Rounds, Internal Medicine
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(Sponsored by St. Mary's Hospital)</p> <p>23 Psychosomia — A Medical Diagnosis
11:45 a.m.-12:45 p.m. — Kennedy Medical Center, Edison
(Sponsored by Kennedy Medical Center)</p> <p>28 Outpatient Management of T.B.
8 p.m. — Warren Hospital, Phillipsburg
(Sponsored by AMNJ and AAFP)</p> |
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OBITUARIES

Dr. Leo Q. Burstein

On October 3, Leo Q. Burstein, M.D., a member of our Union County component, died at his home in Elizabeth. A native of New Jersey, Dr. Burstein received his medical degree from the University of Cincinnati College of Medicine in 1939, and after a period of general practice pursued a residency in surgery at Martland Hospital in Newark. He had been on the surgical staff at Alexian Brothers, St. Elizabeth, and Elizabeth General Hospitals. Dr. Burstein retired from active practice in 1970 and was in the employ of the federal government. His professional memberships included the American Academy of Family Practice, the American Academy of Gastroenterology, and the Association of American Physicians and Surgeons, as well as the American Medical Association. Dr. Burstein was 67 years old at the time of his death.

Dr. Edward W. Chudzik

We have just learned of the sudden death on July 7 of Edward W. Chudzik, M.D., of Bergen County. Born in 1915 and graduated from Marquette University School of Medicine in 1940, Dr. Chudzik was a general practitioner in his native town of Garfield for many years. He was affiliated with St. Joseph's Hospital in Paterson and St. Barnabas Medical Center in Livingston. Dr. Chudzik was a member of the American Academy of Family Practice and of the American Geriatrics Society.

Dr. William F. Costello

At the grand age of 92, William F. Costello, M.D., died on October 3 in Savannah, Georgia, where he currently was residing. A native of Binghamton, New York, Dr. Costello earned his doctorate of medicine in 1907 from the Medical School of the University of Buffalo and practiced industrial medicine in Morris County for several years before establishing a private practice in general surgery in Dover. He was a

Fellow of the American College of Surgeons and a member of the prestigious New Jersey Society of Surgeons and of the Academy of Medicine of New Jersey. He had been on the surgical staff at St. Clare's Hospital in Denville, where for many years he was also the Medical Director; at Dover General, where he was a long-time member of the board of trustees; and at Morristown Memorial and All Souls Hospitals in Morristown.

Dr. Costello was well known in medical society affairs at the county, state, and national levels. He had been president of his county medical society; he was a member of the Board of Trustees of The Medical Society of New Jersey for many years, having served several terms as chairman of that body; he was an AMA delegate from New Jersey; and he was named Vice President of the American Medical Association in 1960. That same year he was the recipient of the Edward J. Ill Award for outstanding service to the medical profession and to the citizens of New Jersey, and in 1957 he had received MSNJ's Golden Merit Award, acknowledging fifty years as a medical practitioner. Dr. Costello was also active in civic affairs, having been on the boards of trustees of several organizations, as well as serving 38 years on the Dover Board of Health, 25 of those years as its president, and as Morris County physician for an equal length of time.

Dr. Costello retired from private practice in 1962, but continued for a time to participate in the emergency departments at St. Clare's, Dover General, and Morristown Memorial Hospitals. In the early 1970s he moved to Wilmington, Delaware, and two years ago to Georgia.

Dr. Irwin P. Davenport

Word has just been received of the death on July 1 of one of Mercer County's senior members, Irwin P. Davenport, M.D. A native of Philadelphia, Dr. Davenport was graduated from Jefferson Medical College, class of 1920, and came to Trenton to establish a practice. He pursued a career in roentgenology and had been on the staff at the Trenton Psychiatric Hospital. He retired in 1969 and was a recipient of MSNJ's Golden Merit Award in 1970. Dr.

Davenport had been a member of the Roentgen Ray Society of North America and of the American Medical Association.

Dr. J. Bennett Edwards

At the grand age of 90, J. Bennett Edwards, M.D., a member from the Bergen County Medical Society, died on September 5. He had earned his medical degree from New York University School of Medicine in 1909 and pursued a residency in radiology, becoming board certified in that specialty. Dr. Edwards, who had been retired for many years, had served a term as president of his county medical society and had been associated with many organizations in his specialty — the American Roentgen Ray Society, of which he was president in 1947-1948; the New York Roentgen Society, of which he also served a term as president, the Radiological Society of North America, the Radiological Society of New Jersey; and the American College of Radiology, in which he held a Fellowship.

Dr. Martin H. Gold

One of Atlantic County's senior members, Martin H. Gold, M.D., of Margate, died on September 19 at Atlantic City Medical Center. A native of Philadelphia, Dr. Gold was graduated from Temple University School of Medicine, class of 1925. He retired to Margate in 1953 and, although no longer practicing medicine, joined the Atlantic County Medical Society and maintained his membership in the American Medical Association. Dr. Gold was 81 years old at the time of his death.

Dr. Walter L. Jordan

One of Bergen County senior members, Walter L. Jordan, M.D., died on September 22 after a long illness. A native of Carbondale, Pennsylvania, Dr. Jordan received his medical education at Temple University School of Medicine, class of 1928, and came to Englewood to practice general medicine, with special interest in urology. He had been on the staff at Englewood Hospital, Holy Name at Teaneck, and Bergen Pines in Paramus. Dr. Jordan was 75 years old at the time of his death.

Dr. Sang Kee Kang

At the untimely age of 36, Sang Kee Kang, M.D., a member of the Monmouth County Medical Society, died on September 2 after a prolonged illness. A native of Korea where he earned his medical degree from the School of Medicine of Seoul National University, Dr. Kang emigrated to the United States ten years ago and took residencies in internal medicine and cardiology at Monmouth Medical Center in Long Branch. He practiced in Holmdel and had staff appointments in the departments of internal medicine and cardiology at Monmouth Medical Center in Long Branch and Bayshore Hospital in Holmdel.

Dr. Peter J. Pizzi

Word has just been received of the death on August 2 of Peter J. Pizzi, M.D., after a long illness. A member of the Cumberland County Medical Society, Dr. Pizzi was an anesthesiologist and was director of that department at the Millville Hospital. Born in 1916, he was graduated from Marquette University School of Medicine, class of 1940, and took a residency at Metropolitan Hospital in New York, becoming board certified in his chosen field. He practiced first in Manchester, Connecticut, and came to Millville in 1950. Dr. Pizzi was a Fellow of the American College of Anesthesiology and a member of the American Society of Anesthesiology, the International College of Anesthesiology, and the New Jersey State Society of Anesthesiologists.

Dr. Robert R. Reilly

At the untimely age of 48, Robert R. Reilly, M.D., a member of our Monmouth County component, died on October 10th after a prolonged illness. A native of New York City, Dr. Reilly was graduated from Georgetown University Medical School in 1954 and practiced general medicine in Sea Girt for eight years before pursuing a residency in clinical psychiatry. He returned to his former office to practice that specialty and was on the staff as assistant attending psychiatrist at Point Pleasant Hospital, the Jersey Shore Medical Center in Neptune, and the New Jersey Psychiatric Hospital at Marlboro.

Dr. Anthony J. Saladino

One of Hudson County's senior members, Anthony J. Saladino, M.D., died on September 13 after a prolonged illness. Born in 1902, Dr. Saladino was graduated from Loyola University School of Medicine (Chicago) in 1928 and returned to New Jersey to establish a general practice in Union City, which he maintained until retirement in 1973. Dr. Saladino had been affiliated with Christ Hospital in Jersey City.

Dr. Joseph G. Villapiano

We have just learned of the death on July 17, from a heart ailment, of Joseph G. Villapiano, M.D., of Asbury Park. A native of Italy, Dr. Villapiano was graduated from Georgetown University School of Medicine in 1924 and pursued residencies in surgery at hospitals in Washington, D.C. and at Postgraduate Hospital in New York. Eventually he came to Monmouth County to practice that specialty and had had staff appointments at Monmouth Memorial and Jersey Shore Medical Centers. He was a Fellow of the International College of Surgeons and of the American College of Proctology. Dr. Villapiano was 79 years old at the time of his death.

Dr. John L. Wikoff

One of Trenton's well-known surgeons, John Leslie Wikoff, M.D., died at his home on October 12, after a prolonged illness. Born at the turn of the century, Dr. Wikoff received his bachelor's degree from Ursinus College and his doctor of medicine degree from Hahnemann Medical College in 1927. He pursued a career in general surgery and was a Fellow of both the American College of Surgeons and the International College of Surgeons. He had been on the surgical staff, ultimately becoming chief of that department, at Helene Fuld Medical Center in Trenton, where he also was a past medical director. He was active in the Mercer County Medical Society, having served a term as its president. At the outbreak of the United States' involvement in World War II, Dr. Wikoff was one of the first physician volunteers and served in the medical department of the Army for four years, nearly all of that time in the Pacific Theater. He retired from active practice in December 1971 for reasons of health.

BOOK REVIEWS

Basic and Clinical Immunology. Fudenberg, Stites, Caldwell, and Well. Las Altas, California, Lange, 1976. Pp. 653. Illus. (\$12.50)

This is an attractively printed, firmly bound, soft-cover book which completely covers the complex field of contemporary knowledge in medical immunology. The book is divided into four sections: "Basic Immunology," with ten subsections; "Immunobiology," with thirteen subsections; "Immunologic Laboratory Tests," with two subsections; and "Clinical Immunology," with sixteen subsections. The table of contents is orderly and complete and the closing index of 23 pages appears to omit nothing in the entire field. Also of special interest is an appendix which includes a "Glossary of Terms" and "Acronyms and Abbreviations" commonly used in immunology. Despite the fact of four editors and some 35 different writers of the various subsections the continuity of thought and flow of information is smooth and orderly, with only minimal overlap. The knowledge presented here clearly establishes that the immunology of today is not just an esoteric exercise for the experimental microbiologist or biochemist but is a necessity for clinician and laboratory specialist. This is indeed a comprehensive review and belongs in the working library of every practicing physician. Because of the different approach of each of the four major sections, the book should be useful to medical students for all four years of their school life.

It is of interest to note in the preface that the editors realize that progress in this field is so rapid that they are already at work on a second edition planned for 1978. Don't wait; buy this one, for the price the amount of information offered is amazing.

Hugh F. Luddecke, M.D.

So Get On With It. Marilee Weisman and Jan Godfrey. Toronto, Canada, Daubleday Canada, Ltd., 1976. Pp. 159 Illus. (\$8.95)

This is a short book with a stirring message. It traces three decades of progress in the care of spinal-cord injured individuals from the time when "those with spinal-cord injuries were thought of as hopeless cripples" to the 1976 Disabled Olympics in Etobicoke (Toronto) Canada, in which "1,000 wheelchair, 300 blind, and 300 amputee athletes from more than 60 countries" competed. The book's subtitle is "A Celebration of Wheelchair Sports."

This small volume consists of a large number of excellent black-white photographs interspersed with short descriptive captions and occasional pages of text where more detailed information needs to be conveyed. In the process it manages to teach a good deal about the medical, psychological, and social problems of the handicapped to those uninformed or not aware. The following author's statements are the messages of the book.

"The ultimate goal of wheelchair sports is a change in attitude: first in the psyche of the athlete who will be able to view himself with healthy respect in the light of his efforts

and accomplishments, and, secondly, in the collective mind of the public. Wheelchair sports involve a minimum of adaptation for the disabled individual. The same is true of everyday life. A disabled individual requires of society only a few adaptations so that he can function."

The text is well written, the illustrations often poignant. It is a worthwhile book which will interest both the sports' lover and the philosopher. The needs of the handicapped are those of every man, and if man is to support his claim to be above the beasts, society must make the necessary adaptations to satisfy those needs "*So Get On With It.*"

L. D. Policoff, M.D.

Help Your Doctor Help You. Walter C. Alvarez, M.D. Millbrae, California, Celestial Arts, 1976. Pp. 126. (Paperback — \$4.95)

Drawing on his many years of experience as a distinguished clinician and writer, Dr. Alvarez has prepared a monograph which should be read by physicians as well as the public at large. It provides useful information in choosing a doctor, the role of specialists, diagnostic tests, surgery, how to manage emergencies, and other topics.

The most important contribution of this book is its illustration of the art of medicine. It emphasizes, in anecdotal fashion, the importance of the history and physical. The reasons for frank and complete interchange are outlined. The patient is advised to respond fully to questions, and the doctor is admonished to *listen*. It illustrates why the wisdom and skill of an experienced clinician cannot be displaced by technology. The narratives touch on the multiplicity of origins of symptoms, the effect of emotional stress, and other variables. Honesty and trust between doctor and patient are stressed.

This book should be recommended by doctors to their patients. It is a good starting point for education of the public on "health" matters. No one can dispute the credentials of the author.

Daniel J. O'Regan, M.D.

Diabetic Cooking Made Easy. V. M. Danahoe. Minneapolis, Minnesota, Burgess, 1976. Pp. 72. (Paperback — \$3.95)

This enlarged revision of *Diabetic Cooking Made Easy* now is available directly from the publisher. Endorsed by the American Diabetes Association, the book is easy to understand and offers much to enlighten and encourage the diabetic to attain variety in meal planning. Helpful sections are those on food preservation, parties, convenience foods, and expanded exchange lists.

Nancy B. Crutchfield, MPH

Live High on Low Fat. Sylvia Rasenthal. Philadelphia, Lippincott, 1975. Pp. 439. (\$9.95)

For anyone considering a diet plan moderately restricted in cholesterol and saturated fats, the revised and enlarged edition of *Live High on Low Fat* could be most helpful. Based on concepts followed by the late Dr. Norman Jolliffe and colleagues, the author has explained the "whys" as well as providing taste-tempting recipes.

Nancy B. Crutchfield, MPH

Ganja in Jamaica: The Effects of Marijuana Use. Vero Rubin and Lombros Comitos. New York, Doubleday/Anchor, 1976. Pp. 217. (Paperback — \$2.95)

Ganja (Marijuana) is primarily used in Jamaica by the working-class males as an energizer. It is used medicinally and taken in teas by women and children for therapeutic purposes. It has been found that for such users there is little reliance on patent medicines, amphetamines, or barbiturates. Ganja has been stated to be a "benevolent alternative" to the heavy use of alcohol by the working-class.

This book is a report of the Jamaica study, sponsored by the Center for Studies of Narcotic and Drug Abuse, National Institute of Mental Health, and is an intensive multi-disciplinary study of marijuana use and users. The study indicates that there is little correlation between use of Ganja and crime; no indications of organic brain damage or chromosome damage; and no significant clinical differences between smokers and controllers. The research demonstrates that the relationship between man and marijuana, is not simply pharmacological.

Ganja use in Jamaica is much more widespread than in the United States, even though Jamaican law is quite clear that cultivating, selling, dealing, and possession are illegal. The major difference between the two countries is that both Ganja use and expected behaviors are culturally conditioned and controlled by well established tradition in Jamaica.

This book is not easy to read since it is a scientific compilation of statistics, data, and facts. It is, however, probably the most authoritative review of the effects of marijuana use available to date.

Seymour F. Kuvin, M.D.

Review of Medical Pharmacology, 5th Edition. Meyers, Jowetz, and Goldfien. Los Altos, California, Lange, 1976. Pp. 740. (Softback — \$12.50)

This biennially re-edited, practical pharmacology text has been updated with respect to both underlying mechanisms and new agents, and warrants its purchase even by those who own a previous edition. Immune mechanisms, cell physiology, actions of antimicrobial and anticancer drugs, the general coverage of fluids and electrolytes, and a rational basis for the classification of psychoactive drugs are all excellent. Three chapters are devoted to toxicology: management of acute intoxications; dangerous metals and chelating agents; common environmental toxic agents. The increasing importance of the effects of drugs on laboratory procedures is recognized in an expanded Appendix devoted to this subject.

The listings of available drugs and dosage forms is not complete. A quick check revealed the omissions of prazosin, recently approved for hypertension, of cephapitin, a cephalosporin which has been available for a few years, and of the chewable form of ISDN.

While reviewing the section on vasodilator drugs, no discussion of the use of nitrates in acute myocardial infarction or congestive heart failure was encountered. In fact, for angina, the prediction is made by the authors that with the advent of effective treatment for hypertension, coronary bypass surgery and propranolol, the use of nitrates should soon end, a prediction not shared by this reviewer.

Everything taken into account this is a useful general pharmacology text.

Hyman W. Fisher, M.D.

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THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

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1976

Society established July 23, 1766
Journal founded September 1, 1904

VOLUME 73

JANUARY TO DECEMBER, 1976

Published monthly under direction of the
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315 WEST STATE STREET
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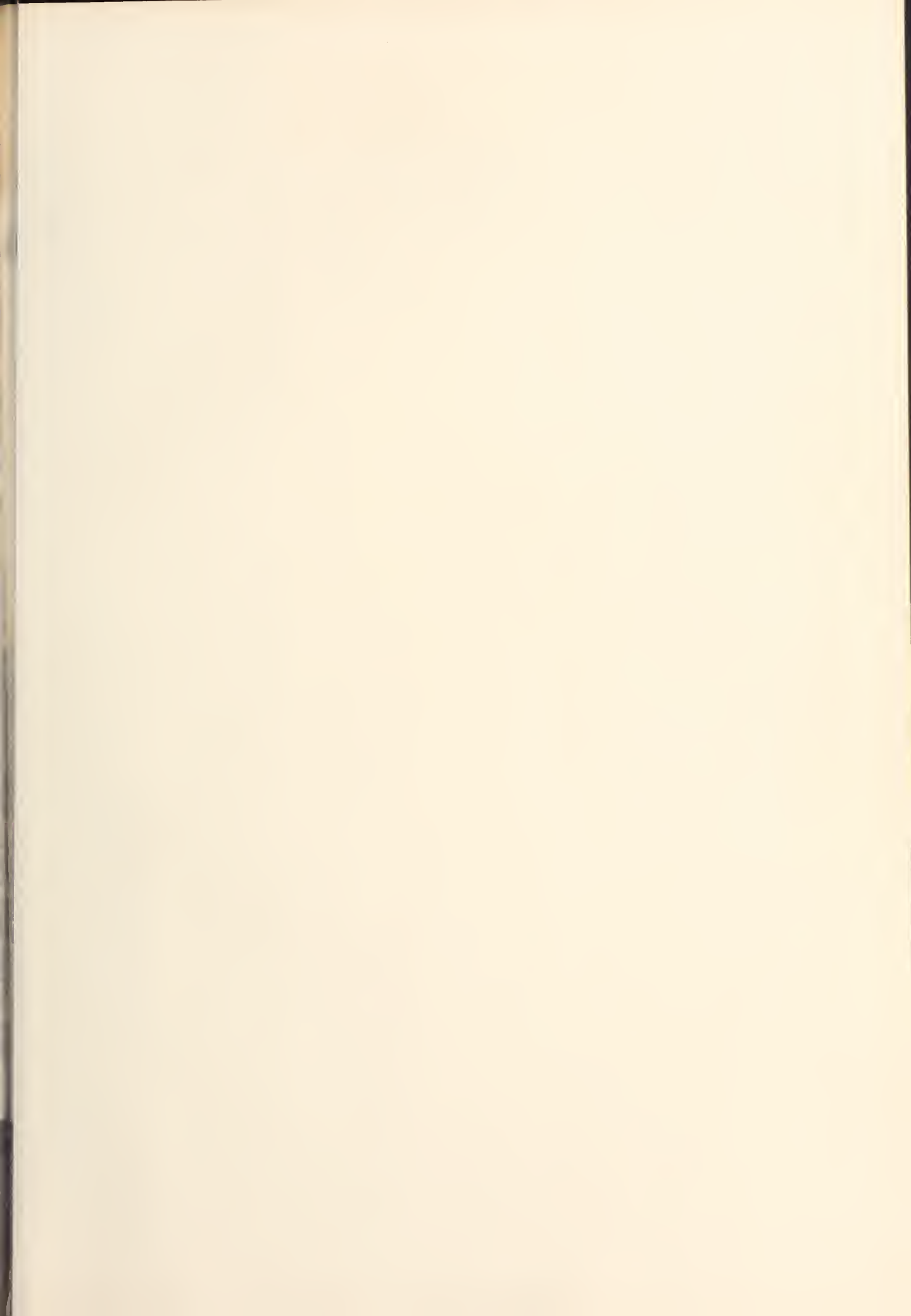
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